Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✔ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient**

Date________/_________/_________

Version 01/02

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation **Date** ________/________/________

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date** ________/________/________

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

.... Postcode: ....

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _______/_______/_______

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Ethnicity (please circle below):

WHITE	MIXED	Asian/Asian British	Black/Black British	Other
British	White & Black Caribbean	Indian	Caribbean	Chinese
Irish	White & Black African	Pakistani	African	Other
European	White & Asian	Bangladeshi	Other	
Other	Other	Other		

DOCUMENTATION REQUIRED FOR PATIENTS NEWLY REGISTERING;

1. Photo ID for Adults e.g. Passport, Drivers Licence with patient present
2. Children under age of 16 we require full birth certificate only
3. Current proof of address in practice area e.g. recent Utility Bill, wage slip, Drivers Licence, Bank Statement, Tenancy Agreement, mortgage docu7ment, Council Tax Bill or benefits information.
4. Registration form completed inc **DOB, Place of Birth, previous Address** and **previous GP**
5. **Registration Form Signed**

Patients from **ABROAD** (who have not been registered with a UK GP before)

1. Same as above **PLUS**:
2. Proof of entitlement to be in UK for more than 6 months. **This paperwork is photocopied.**
    a. (for students a visa or letter from education establishment)
    b. For workers, a visa, residence permit or work permit

If patient does not fit these criteria they will be treated as a **PRIVATE PAYING PATIENT**

IF PAPERWORK IS NOT PROVIDED WE CAN ONLY REGISTER YOU AS A TEMPORARY PATIENT FOR A MAXIMUM OF 3 MONTHS, UNTIL I.D. ETC IS PRESENTED

WHEN REGISTERING AT PMG IT WOULD BE BEST, IF POSSIBLE, IF YOU COME TO THE SURGERY BETWEEN 12.30 AND 2.OOPM OR AFTER 4.30 PM, OUR QUIETER TIMES. THANK YOU.

Receptionists name:___________________________ Photocopies_____________

NEW PATIENT REGISTRATION INFORMATION FORM

Thank you for taking the time to complete this form in as much detail as possible. However, please note that some of the information is being requested by the Department of Health so that we can provide you with a better Primary Care Service.

If you are a new patient to PMG please make an appointment for a **New Patient Check** when you have received our registration confirmation letter as this enables us to introduce ourselves and also to carry out basic checks on your present state of health.

SURNAME:……

FORENAMES:……

TITLE:……………. DATE OF BIRTH:…………………………… MARITAL STATUS:…………………………….

ADDRESS:……

……

………………………………………………………………………………………… POSTCODE:………………………………….

TEL NO:………………………………………………………… MOBILE NO:…………………………………………….

EMAIL:…….

Next of Kin's Full Name and address. Please state relationship to you and their Tel No:

……

……

Postcode:……………………………………………… Tel No:……………………………………………………………..

First Language: English…………………………… Other:…………………………………………………………….

<u>COMMUNICATION</u> – DO YOU NEED US TO COMMUNICATE WITH YOU IN A DIFFERENT WAY, FOR EXAMPLE LARGE PRINT, BRAILLE, SIGN LANGUAGE, INTERPRETER SERVICES REQUIRED ETC?

IF YES PLEASE ADVISE…………………………………………………………………………………

……

ALCOHOL (AGE 16+ TO COMPLETE)

How many **units** do you usually drink per week?:...

What is a UNIT?

A pint of Regular Beer/Larger/Cider is = **2 UNITS**

One bottle of alcopop of can of larger is = **1.5 UNITS**

One small glass of wine (175ml) is = **2 UNITS**

One single small measure of spirits is = **1 UNIT**

One bottle of wine is = **9 UNITS**

SMOKING

Please tick as appropriate:

Current Smoker: ☐ How many do you smoke per day?...........................

Ex Smoker Quit Date:..................... How many did you smoke per day?......................

Never Smoked Tobacco: ☐

ABOUT YOU:

What is your occupation?...

MEDICATION? If you require regular medication – please **ATTACH A CURRENT PRESCRIPTION SLIP** showing your current medication requirements so that these may be added to your records.

Do you have any **drug allergies** or other **sensitivities** (i.e. to plasters)?

....

....

....

Your **Past Medical History** (operations, illnesses etc)

....

....

....

Family History (*only* mother, father, brother or sister who died under the age of 65 and reason)

....

....

Are you a carer? (A **carer** is anyone who cares, unpaid, for a friend or family member who due to illness, disability or a mental health problem) If your answer is yes, please give the name and relationship to you of the person you are caring for and we will send out a carers registration pack to you:

Yes.............. Name and relationship;...

Contraception method (for women only):...

SystmOne Online – Patient Application Form

You just need to bring along some photographic proof of ID (i.e. Passport or Driving Licence) to get registration details. To ensure confidentiality we are only able to accept registrations in person – i.e. you cannot give your details to anyone else to register for you.
Please take this to reception to be given a log in (Tuesday/Wednesday/Friday after 2pm only)

We are unable to give access to SystmOne Online for patients under the age of 16.

Name of person for the online access	
Date of Birth	**Age**

Patient Disclaimer 1 (application in person over 16 yrs)

I …………………………………………………………………………….. have understood and will adhere to the Pulborough Medical Group Practice Guidance notes which I have been given for the use of SystmOne Online. It is my responsibility to keep my account secure by keeping my log in details confidential. I understand that I can terminate my account at any time by contacting the surgery, or change my log in details by re-registering, and that this form will be kept on my electronic records.

Signed ………………………………………………………….. Date ……………………………………………

Please tick if you would like access to your detailed coded medical record. ☐

The following information is optional but very useful for us to keep our records up to date, please tick appropriate box:

I have never smoked ☐ I am an ex-smoker ☐ I am a current smoker ☐

If you are a **current smoker** we are required to offer BOTH support and treatment to stop smoking.

Please tick below-

I am **not interested** in either support/treatment ☐

I **am interested** in either support/treatment ☐ **Please make an appointment with a Pharmacist to discuss**

Email Address ………………………………………………………………………………………………..…

Mobile telephone number ………………………………………………………………………………

If you have supplied a mobile telephone number you will receive text message appointment reminders and occasional messages/test results. Please tick if you **DO NOT** want to received text messages by the surgery ☐

Document now to be scanned onto patient record and then shredded please.

Patient Guidance notes for SystmOne Online

We are pleased to offer you the facility to use "SystmOne Online" which provides internet services for patients. For patients under the age of 16 years parental / guardian and patient access is not permissible

Online you can:

- View, book or cancel doctor appointments
- View a list of your current repeat medication and send repeat prescription requests.
- View your detailed coded medical record

Please note that other medical records are not accessible.

Appointments
At the moment, only GP appointments are available to book online - for nurses appointments please continue to contact the surgery. If you are unsure as to whether you need a GP or a nurse appointment, please contact the surgery.

Appointment times are currently set at 10 minutes, if you feel that you need longer with your doctor, please contact the surgery to make an appropriate appointment.

If you subsequently decide that you no longer require the appointment, please ensure that it is cancelled to enable the time to be offered to someone else – please cancel by either the online system or by telephoning the surgery.

(Failure to cancel on line appointments could result in your online account being removed)

Repeat prescriptions
Please note that when requesting a repeat prescription, you need to state in the comments box which pharmacy you would like it sent to.

We still require 3 working days to process requests.

Registering
To register please complete the 'SystmOne Online – Patient Application Form' (available on the surgery website or from reception)

Please note the following disclaimer if applying for online registration:

You agree to adhere to the Pulborough Medical Group Practice Guidance notes for the use of SystmOne Online. It is your responsibility to keep the account secure by keeping the log in details confidential. You understand that you can terminate the account at any time by contacting the surgery, or change the log in details by re-registering, and that this form will be kept on the clinical electronic records. Access to communications by the patient is the responsibility of the patient and the surgery accepts no responsibility for communications used but not processed by the surgery.

You will need photographic proof of identification eg. passport or driving licence & to ensure confidentiality we are only able to accept registrations in person so you cannot give your details to anyone else to register for you.

Our reception staff will quickly register you and provide you with unique log in details and instructions for the website.

Any questions – please ask your Pharmacy, not the Doctors Surgery

A new way to get your medicines and appliances – Available to you from 8th October

The Electronic Prescription Service (EPS) is an NHS service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from. PLEASE REGISTER WITH A PHARMACY NOW

What does this mean for you?

If you collect your repeat prescriptions from your GP you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to the place you choose, saving you time.

You will have more choice about where to get your medicines from because they can be collected from a pharmacy near to where you live, work or shop.

You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive.

Is this service right for you?

Yes, if you have a stable condition and you:

- don't want to go to your GP practice every time to collect your repeat prescription.
- collect your medicines from the same place most of the time or use a prescription collection service now.

It may not be if you:

- don't get prescriptions very often.
- pick up your medicines from different places.

How can you use EPS?

You need to choose a place for your GP practice to electronically send your prescription to. This is called nomination. You can choose:

- any Pharmacy.
- a dispensing appliance contractor (if you use one).

Any questions – please ask your Pharmacy, not the Doctors Surgery

Ask any pharmacy or dispensing appliance contractor that offers EPS. You don't need a computer to do this. All our local Pharmacies can help register you.

Can I change my nomination or cancel it and get a paper prescription?

Yes you can. If you don't want your prescription to be sent electronically tell your Pharmacy. If you want to change or cancel your nomination speak to any pharmacist or dispensing appliance contractor that offers EPS. Tell them before your next prescription is due or your prescription may be sent to the wrong place.

Is EPS reliable, secure and confidential?

Yes. Your electronic prescription will be seen by the same people in GP practices, pharmacies and NHS prescription payment and fraud agencies that see your paper prescription now.

Sometimes dispensers may see that you have nominated another dispenser. For example, if you forget who you have nominated and ask them to check or, if you have nominated more than one dispenser. Dispensers will also see all the items on your reorder slip if you are on repeat prescriptions.

If you are unhappy with your experience of nomination

You can complain to the pharmacy, dispensing appliance contractor (DAC) or GP practice. You can also complain to NHS England or their local NHS Clinical Commissioning Group (CCG) if your complaint cannot be resolved www.england.nhs.uk/contact-us/complaint/

For more information visit
www.hscic.gov.uk/epspatients, your pharmacy or GP practice. (Dec 2014)

Electronic Prescription Service
Patient Nomination Request

Patient name ………………………………………………………………………………………………

Address ……………………………………………………………………………………………………

………

Telephone Number…..…………………………………………………………………………………

DOB ………………………………………………………………………………………………………..

NHS Number (if known) …………………………………………………………………………………

I am the patient named above/carer of the patient named above. Nomination has been explained to me and I have also been offered a leaflet that explains nomination.

PLEASE WRITE DOWN THE *NAME AND ADDRESS* OF YOUR NOMINATED PHARMACY HERE:

Patient Signature……………………………………………………………………………

Date………………………………………………………………..…………………………….

Communicating with our patients

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.

- We want to know if you need information in braille, large print or easy read.
- We want to know if you need a British Sign Language interpreter or advocate.
- We want to know if we can support you to lipread or use a hearing aid or communication tool.

Please tell the receptionist when you arrive for your next appointment, or call us on 01798 872815 between 2.30pm and 5.30pm and ask for the Admin Department

Thank you

CONSENT FORM FOR TELEPHONE AND SMS MESSAGES

Dear New Patient

Please let us know if you **DO NOT** consent to us leaving a telephone message or sending an SMS regarding your healthcare to either your home or mobile telephone numbers. With thanks.

Tick here if you DO NOT consent

1) Your mobile number ☐

2) Your home number ☐

*** Please note – we do not leave detailed medical messages**

PULBOROUGH PATIENT LINK
CONSENT TO USE A SECURE EMAIL ADDRESS

Pulborough Patient Link (PPL) is an association of patients of Pulborough Medical Group (PMG) which aims to promote a better understanding of patient concerns and of PMG services. They hold regular committee meetings, produce a Newsletter 3 times a year and organise health events. If you would like to receive copies of the PPL's Newsletters and details of their health events by email, please complete and return this form to the Surgery.

I ………………………………………………………………………….. consent to the staff of Pulborough Medical Group being able to use the Email address given below to send me copies of the Pulborough Patient Link (PPL) Newsletter and information on any PPL Events. I have informed them that this is a secure Email address

Email address ……………………………………………………………………….

(**please print clearly**)

I understand that this email address will not be stored on my patient record, or be passed to any other person(s) and will not be used for any other purpose than the circulation of information from the patient link group – PPL.

Change of Email address

I understand that it will be my responsibility to advise the Practice in the event of any changes and I will need to complete another form with my new email address and signed consent.

Signed ……………………………………………… Date ……………………..

Dissent from secondary use of patient identifiable data

Dear Doctor,

I am writing to give notice that I refuse consent for my identifiable information and the identifiable information of those for whom I am responsible [***delete as appropriate***] to be transferred from your practice systems for any purpose other than my medical care.

Please take whatever steps necessary to ensure my/our [***delete as appropriate***] confidential personal information is not uploaded and record my dissent by whatever means possible.

This includes adding the '**Dissent from secondary use of GP patient identifiable data'** code (Read v2: 9Nu0 or CTV3: XaZ89) to my record as well as the '**Dissent from disclosure of personal confidential data by Health and Social Care Information Centre**' code (Read v2: 9Nu4 or CTV3: XaaVL).

I am aware of the implications of this request, understand that it will not affect the care I/we receive and will notify you should I change my mind.

Yours sincerely,

Name	
Date	

Information to help identify my records

Title	
Surname/Family name	
Address	
Post code	
Date of birth	
NHS number (if known)	

Additional patients

Dear Doctor,

Please take whatever steps necessary to ensure the following people's confidential personal information is not uploaded from your practice and record my dissent on their behalf by whatever means possible.

Title	
Surname/Family name	
Address	
Post code	
Date of birth	
NHS number (if known)	

Title	
Surname/Family name	
Address	
Post code	
Date of birth	
NHS number (if known)	

You can provide details of other family members you wish to opt out on a separate sheet, but make sure this letter is attached.

YOUR EMERGENCY CARE SUMMARY RECORD

Dear Patient

Summary Care Record –your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record –** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.

If you need more time to make your choice you should let your GP Practice know. For more information talk to our Patient Advice and Liaison Service (PALS) on 01903 505456, GP practice staff, visit the website **www.westsussex.nhs.uk/summary-care-records** or **www.nhscarerecords.nhs.uk**, or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

OPT-OUT FORM - confidential

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title………………………… Surname/Family Name……………………………………………………….

Forenames………………………………………………………………………………………………………

Address: ……………………………………………………………………………………………………….

……

……

Postcode:……………………………… Home Telephone Number………………………………………….

DOB……………………………………... Mobile Number…………………………………………………..

NHS Number (if known)... Signature..

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your Name……………………………………………………………… Your Signature………………………….

Relationship to patient………………………………………………… Date………………………………………

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.	Your records will stay as they are now with information being shared by letter, email, fax or phone.	If you have any questions, or if you want to discuss your choices, please: • phone the Summary Care Record Information Line on 0300 123 3020; • contact your local Patient Advice Liaison Service (PALS); or • contact your GP practice.