NHS 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 d d m m y y

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone No:

Mobile No:

Email Address:

Are you a carer? ☐

Do you have a carer? ☐

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/or have ever been in the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

Date Left

If you are registering a child under five.

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

If you are registering a child under 16 (only complete if the answers below are 'yes')

☐ Does the child have a Child Protection Plan?

☐ Does the child have a Child in Need Plan?

Online Access

Would you like to book Appointments, order Repeat Prescriptions and view your Immunisation Record online? If so, please tick this box and we will send the Patient Access registration codes to your residential address. ☐

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

Date

....

Please see overleaf re: Organ donation

Family doctor services registration

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

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 0845 60 60 400

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 three 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 the 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

Practice Stamp

Name Date

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

STRAWBERRY HILL MEDICAL CENTRE

Ethnicity Recording

The Department of Health (DoH) has asked the practice to record the ethnic origin and first language of all new patients. This information will be added to your medical record.

Name: **Date of Birth:**

Your Ethnic Origin
(Please tick the description which you feel is most appropriate)

African ☐
Bangladeshi or British Bangladeshi ☐
British or Mixed British ☐
Caribbean ☐
Chinese ☐
Information Refused ☐
Indian or British Indian ☐
Irish ☐
Other Asian background ☐
Other black background ☐
Other mixed background ☐
Other white background ☐
Other ☐
Pakistani or British Pakistani ☐
White and Asian ☐
White and Black African ☐
White & Black Caribbean ☐

YOUR FIRST LANGUAGE

English ☐

If your first language is not English, please tick here if you require an interpreter/translator ☐

Please select your first language on the next page……

Abkhazian ☐	Afar ☐	Afrikaans ☐
Akan ☐	Albania ☐	American SL ☐
Amharic ☐	Arabic ☐	Aragonese ☐
Armenian ☐	Assames ☐	Australian SL ☐
Avaric ☐	Avestan ☐	Aymara ☐
Azerbaijani ☐	Bambara ☐	Bamoun ☐
Bamun ☐	Bashkir ☐	Basque ☐
Belarusian ☐	Bengali ☐	Bihari ☐
Bislama ☐	Bokmal (Norwegian) ☐	Bosnian ☐
Braille ☐	Brawa ☐	British Sign Language ☐
Breton ☐	Bulgarian ☐	Burmese ☐
Cantonese ☐	Catalan ☐	Central Khmer ☐
Chamorro ☐	Chechen ☐	Chichewa ☐
Chinese ☐	Church Slavic ☐	Chuvash ☐
Cornish ☐	Corsican ☐	Cree ☐
Croatian ☐	Czech ☐	Danish ☐
Dari ☐	Divehi ☐	Dutch ☐
Dzongkha ☐	Esperanto ☐	Estonian ☐
Ethiopian ☐	Ewe ☐	Faeroese ☐
Faroese ☐	Farsi ☐	Fijian ☐
Filipino ☐	Finnish ☐	Flemish ☐
French ☐	French Creole ☐	Frisian ☐
Fulah ☐	Gaelic ☐	Galician ☐
Georgian ☐	German ☐	Greek ☐
Greenlandic ☐	Guarani ☐	Gujerati ☐
Haitian ☐	Hakka ☐	Hausa ☐
Hebrew ☐	Herero ☐	Hindi ☐
Hindko ☐	Hin Motu ☐	Hungarian ☐
Iba ☐	Iban ☐	Icelandic ☐
Iddo ☐	Igbo (Ibo) ☐	Indonesian ☐
Interlingua ☐	Interlingue ☐	Inuktitut ☐
Inupiaq ☐	Irish ☐	Italian ☐
Japanese ☐	Javanese ☐	Kalaallisut ☐
Kannada ☐	Kanuri ☐	Kashmiri ☐
Kazakh ☐	Kikuyu ☐	Kinyarwanda ☐
Kirghiz ☐	Komi ☐	Kongo ☐
Konkani ☐	Korean ☐	Kuanyama ☐
Kurdish ☐	Kutchi ☐	Lao ☐
Latvian ☐	Limburgan ☐	Lingala ☐
Lithuanian ☐	Luba-Katanga ☐	Luganda ☐
Luxembourgish ☐	Macedonian ☐	Makaton SL ☐

P.T.O

Malagasy	☐	Malay	☐	Malayam	☐
Maltese	☐	Mandarin	☐	Manx	☐
Maori	☐	Marathi	☐	Marshallese	☐
Moldavian	☐	Mongolian	☐	Nauru	☐
Navajo	☐	Ndebele	☐	Ndebele (North)	☐
Ndebele (South)	☐	Ndongo	☐	Nepali	☐
Northern Sami	☐	Norwegian	☐	Occitan	☐
Ojibwa	☐	Oriya	☐	Oromo	☐
Ossetian	☐	Pali	☐	Panjabi	☐
Pashto	☐	Patois	☐	Persian	☐
Polish	☐	Portuguese	☐	Punjabi	☐
Pushto	☐	Quechua	☐	Romanian	☐
Romansh	☐	Rundi	☐	Russian	☐
Samoan	☐	Sango	☐	Sanskrit	☐
Sardinian	☐	Serbian	☐	Serbo-Croatian	☐
Shona	☐	Sichuan Yi	☐	Sindhi	☐
Sinhala	☐	Sinhalese	☐	Slovak	☐
Slovenian	☐	Somali	☐	Sorani Kurdish	☐
Southern Sotho	☐	Spanish	☐	Sundanese	☐
Swahili	☐	Swati	☐	Swedish	☐
Sylheti	☐	Tagalog	☐	Tahitian	☐
Tajik	☐	Tamil	☐	Tatar	☐
Telugu	☐	Tetum	☐	Thai	☐
Tibetan	☐	Tigrinya	☐	Tongan	☐
Tsonga	☐	Tswana	☐	Turkish	☐
Turkmen	☐	Twi	☐	Uighur	☐
Ukranian	☐	Urdu	☐	Uzbek	☐
Venda	☐	Vietnamese	☐	Volapuk	☐
Walloon	☐	Welsh	☐	Western Frisian	☐
Wolof	☐	Xhosa	☐	Yiddish	☐
Yoruba	☐	Zhuang	☐	Zulu	☐

Other	☐	Not Stated	☐

STRAWBERRY HILL MEDICAL CENTRE

ARE YOU A CARER?

- Do you offer unpaid support to a friend or relative who couldn't manage without your help?
- Maybe you are supporting someone who is ill, frail, disabled or has mental health or substance misuse problems?

If so, you are a carer and we would like to support you.

Supporting someone can be really rewarding but also can be quite challenging at times. It is vital people who care for others ensure they consider their own health and wellbeing too.

We are committed at Strawberry Hill Medical Centre to ensuring carers are aware they are not alone. There is a range of support available and we would like to ensure you are aware of the support that could be really beneficial to you.

Please complete this form in **BLOCK CAPITALS** and hand it in to reception.

Your Details:

Full name	
Date of birth	
Address	
Postcode	
Telephone number	
Relationship to the person you care for	
Any other relevant information	

Details of the person you look after / care for:

Full name	
Date of birth	
Address (If different from above)	
Postcode	
Telephone number (If different from above)	
GP details (If different from your own)	
Any other relevant information	

FOR STAFF USE: PLEASE ENTER READ CODE – **IS A CARER: 918G / HAS A CARER: 918F**

Increasing Patient Participation in Strawberry Hill Medical Centre

The surgery is working towards a newly formed Patient Group for Strawberry Hill Medical Centre. The Patient Group plays a valuable part in the future development of the Practice and proactively provide feedback on the range and quality of our services and generate ideas for areas to improve.

We would like to recruit patients for the Patient Group from as broad a spectrum as possible. If you would like to join, please fill in this form and hand it back to reception.

Name: ………………………………………………………………

Email address: ………………………………………………………………

Date of Birth: …………………………………………….........................

This additional information will help to make sure we try to speak to a representative sample of the patients that are registered at this practice.

Are you? Male ◻ Female ◻

Age:	Under 16	◻	17 - 24	◻
	25 – 34	◻	35 – 44	◻
	45 – 54	◻	55 – 64	◻
	65 – 74	◻	75 - 84	◻
	Over 84	◻		

To help us ensure our contact list is representative of our local community please indicate which of the following ethnic background you would most closely identify with?

White					
British Group	◻	Irish	◻		
Mixed					
White & Black Caribbean	◻	White & Black	◻	White &	◻
Asian or Asian British					
Indian	◻	Pakistani	◻	Bangladeshi	◻
Black or Black British					
Caribbean	◻	African	◻		
Chinese or other ethnic					
Chinese	◻	Any Other	◻		

How would you describe how often you come to the practice?

Regularly	◻
Occasionally	◻
Very rarely	◻

Thank you – please return your completed form to reception.

Please note that no medical information or questions will be responded to.
The information you supply us will be used lawfully, in accordance with the Data Protection Act) 1998. The Data Protection Act 1998 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.

<u>STRAWBERRY HILL MEDICAL CENTRE</u>
<u>COMMUNICATION</u>

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 lip read or use a hearing aid or communication tool.

Please tell the receptionist when you arrive for your next appointment, or call us on 01635 917 917 between 11am and 5pm and ask to speak with Penny.

Thank you.

Patient Access Application Form

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	
2. I will be responsible for the security of the information that I see or download	
3. If I choose to share my information with anyone else, this is at my own risk	
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching Vouching with information in record ☐Photo ID and proof of residence
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation