Dr. Gordon J. Barron
Dr. Michael J. Mckemey
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All correspondence to:
Purton Surgery
High Street
Purton
Swindon
Wiltshire
SN5 4BD
☎ 01793 770207

Dear New Patient

Welcome to Purton Medical Practice

To register as a new patient you need to complete a Registration Form, Ethnic origin form and a New Patient Questionnaire for each patient joining our practice list. We would be grateful if you could complete these forms as fully as possible as it will provide us with the essential information we need for our records.

**Please note we are unable to register you with the practice until we have all these completed forms returned to us.**

We also offer the facility to book appointments for Doctors and request repeat medication on line, please complete the relevant form in the registration pack and return to the Surgery with photo identification, **at least one week after bringing in your registration forms.**

We **do not** routinely ask you to visit the nurse for a new patient check as we know that some people find it difficult to attend appointments. Once registered, the Nurse also checks the questionnaires and enters the relevant information to your records, if she feels that it may be helpful for her to meet you to obtain further information and maybe for further routine tests, we will contact you and ask you to make an appointment.

**If you are on regular repeat medication, you will need to make a routine Doctors appointment before we can issue a prescription, again once you are registered we will be able to do this, so please allow 24 hours after bringing in your forms before contacting the Surgery for an appointment.**

We have a very informative website which you may like to browse: - **www.purtonsurgery.co.uk.**

Could I also take the opportunity to mention that we have an active patient participation group (this is a group made up from our registered patients), the 'G4P' group help organise health promotions, talks and other events. We are very grateful to anybody who is able to support G4P in any way they can. Please contact Kai Howard (Practice Manager) at the Surgery if you would like any further details about the group.

Please contact the Surgery if you have any questions, our Receptionists will be happy to help.

Yours sincerely

Mr Kai Howard
Practice Manager

# 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

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*

*Not all doctors are authorised to dispense medicines*

☐ 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

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date_____/_____/_____

### 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:

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

042017_003 Product Code: **GMS1**

# Family doctor services registration

GMS1

## 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

**SUPPLEMENTARY QUESTIONS**

**PATIENT DECLARATION for all patients who are not ordinarily resident in the UK**

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.**

**The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.**

**Please tick one of the following boxes:**

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

**A parent/guardian should complete the form on behalf of a child under 16.**

| | | | |
|---|---|---|---|
| **Signed:** | | **Date:** | DD MM YY |
| **Print name:** | | **Relationship to patient:** | |
| **On behalf of:** | | | |

**Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.**

**NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS**

| | | |
|---|---|---|
| Do you have a non-UK EHIC or PRC? | **YES:** ☐ **NO:** ☐ | If yes, please enter details from your EHIC or PRC below: |
| | Country Code: | |
| | 3: Name | |
| | 4: Given Names | |
| | 5: Date of Birth | DD MM YYYY |
| | 6: Personal Identification Number | |
| | 7: Identification number of the institution | |
| | 8: Identification number of the card | |
| | 9: Expiry Date | DD MM YYYY |
| PRC validity period (a) From: | DD MM YYYY | (b) To: DD MM YYYY |

*If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.*

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff**.

**How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home countr

# Purton Surgery New Patient Questionairre

Please complete as much of the information on this form as you can and return it to the Surgery along with your Registration Forms. Thank you

Title : …….....

Surname : …….....

Forenames : ……

Date of birth : ……

Address : ……..

……

……..Postcode : ……..

Home tel no : …….. …. Mobile tel no : ……

Occupation / School :……..

Next of kin : ……..

Relationship of next of kin : ……...

Contact No for next of kin : ……

**MEDICAL HISTORY**

Please list below any major illnesses/ operations (in date order if possible) – please continue on a separate sheet if necessary.

| **DATE** | **ILLNESS/OPERATION** |
|---|---|
| | |
| | |
| | |
| | |

| **Do you have any drug allergies** | **Yes / No** |
|---|---|
| **If yes please specify** | |

Please list below all the medicines prescribed for you at present - Please use a separate sheet if needed.

| **Name of Medication** | **Strength of tablet (e.g 2.5 mg)** | **Dose i.e 1 tablet daily** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Family History**

Please list below any major illnesses e.g High blood pressure, Diabetes, Asthma, Heart Disease, suffered by a close relative i.e Father, mother, brother, sister.

| **Family Member** | **Illlness** |
|---|---|
| | |
| | |
| | |

**LIFESTYLE**

| | | |
|---|---|---|
| **Do you smoke**<br>**Yes**<br>**No**<br>**Ex Smoker** | **If yes – Cigarettes**<br>**Roll your own**<br>**Cigars**<br>**Pipe** | **How many per day** |
| **Do you drink alcohol** | **If yes – how many units per week**<br>**1 unit = 1 small glass of wine**<br>**1 measure of spirits or ½ pint beer** | **How many units per week** |

| | | | |
|---|---|---|---|
| **HEIGHT** | | **WEIGHT** | |

**Do you exercise ?**

| | |
|---|---|
| **Type of exercise** | |
| | |
| **How often i.e 1 week 2-3 times weeks** | |

**IMMUNISATIONS**

Have you ever had a course of Tetanus & Polio Vaccine: **YES / NO DATE :** .....

If you are aged between 18 and 24 have you had a Men C Vaccination

**YES / NO DATE**: ……

If the answer is no to either of these questions above, please make an appointment with one of our Practice Nurses to update your immunisation cover,

**FEMALE PATIENTS**

If you use Contraception – what type do you use at present : ……

If you have a coil fitted – please answer the following questions :

| **What type e.g. Mirena** | **When was it inserted** | **Where was it inserted e.g Hospital or GP** | **When was it last checked** |
|---|---|---|---|
| | | | |

All information is given in the belief that it is correct at this time.

Signed ……. Date ……...

Patient Name _____ Date of Birth _____

1. **How often do you have a drink containing alcohol?**

   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**

   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 or 9
   - ☐ e 10 or more

3. **How often do you have six or more drinks on one occasion?**

   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

All information is given in the belief that it is correct at this time.

Signed ……. Date ……...

**COLLECTING INFORMATION ABOUT YOUR ETHNIC ORIGIN**

Everyone belongs to an Ethnic group, so all our patients and service users are asked to describe their ethnic group

We are collecting this information to help the NHS and Social Services.

❄ Understand the needs of patients and Service Users from different groups and so to provide a better and more appropriate service for you

❄ Identify risk factors – some groups are more at risk of specific diseases and care need, so ethnic group data can help treat these patients and support Service Users, by alerting staff to high risk groups.

❄ Improve public health by making sure that our services are reaching all our local communities and that we are delivering our services fairly to everyone who needs them.

❄ Comply with the Law as Race Relations (Amendment Act 2000) – gives public authorities a duty to promote race equality and good race relations and ethnic monitoring is important in making sure that race discrimination is not taking place.

**NAME :**

**ADDRESS :**

**MOBILE TEL NO :**

**E MAIL ADDRESS :**

White

| | |
|---|---|
| | British |
| | White |
| | Other White |

Mixed

| | |
|---|---|
| | Mixed white & black Caribbean |
| | Mixed white & black African |
| | Mixed white & Asian |
| | Other Mixed |

Asian or Asian British

| | |
|---|---|
| | Indian |
| | Pakistani |
| | Bangladeshi |
| | Other Asian |

Black or British Black

| | |
|---|---|
| | Caribbean |
| | African |
| | Other Black |

Other

| | |
|---|---|
| | |

# NHS Summary Care Record with additional information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

**You can choose** to have additional information included in your SCR, which can enhance the care you receive. This information includes:

- Your illnesses and health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated - such as where you would prefer to receive care
- What support you might need
- Who should be contacted for more information about you

## What to do next

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form, for return to the relevant GP surgery.

Name of Patient: ……

Date of Birth: …….  Patient's Postcode: ……

Surgery Name: ……..  Surgery Location (Town): …….....

NHS Number (if known): ……

Signature: …….. Date: …….

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; **you** sign the form above and provide your details below:

Name: ……

Capacity:

Please circle one

| Parent | Legal Guardian | Lasting power of attorney for health and welfare |
|---|---|---|

If you require any more information, please visit **www.hscic.gov.uk/scr/patient** phone HSCIC on **0300 303 5678** or speak to your GP Practice

**For practice use:** To update the patient's consent status to 'Express consent for medication, allergies, adverse reactions and Additional Information' use the SCR consent preference dialogue box or add Read code **9Ndn** (or CTV3 code **XaXbZ** for SystmOne practices).