Office use only

|  |  |
| --- | --- |
| Reg form GMS1 |  |
| Data entry form |  |
| Cytology / Imms |  |
| HCA Review |  |
| Parent / child  |  |

Member of staff receiving form

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**FAMILY DOCTOR SERVICES REGISTRATION [GMS1]**

Patient details:

Complete in **BLOCK CAPITALS** and **\*delete as appropriate**

Please email completed form to: swlccg.stpcadmin@nhs.net

**IF YOU HAVE SPECIAL NEEDS, WE CAN HELP YOU.**

**PLEASE LET US KNOW.**

|  |  |
| --- | --- |
| Mr/Mrs/Miss/Ms \* | Surname:  |
| Male/Female \* | First Names:  |
| Date of Birth | Previous surnames: |
| NHS No: | Town and country of birth: |
| Home Address: Postcode: Telephone No: Mobile phone No: Email address: |
| **Please help us to trace your previous medical records by providing the following information:**Your previous address in UK:Name and address of your previous doctor whilst at the above address: |
| **If you are from abroad:**Your first UK address where registered with a GPIf previously resident in UK Date you first cameYour date of leaving to live in the 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 |
| **Please nominate a pharmacy for your prescriptions**Pharmacy name and address:  |
| . Date **Patient Signature**  |
| **HA use only**: Patient registered for: ❑ GMS ❑ CHS ❑ Dispensing ❑ Rural Practice  |

**FAMILY DOCTOR SERVICES REGISTRATION GMS1 – Page 2**

**Please complete in BLOCK CAPITALS and \*delete as appropriate**

|  |  |
| --- | --- |
| **Surname:** | **First Names:** |
| **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 indicate organs/tissue you would like to donate:-KIDNEYS/HEART/LIVER/CORNEAS/LUNGS/PANCREAS/ANY PART OF MY BODY**\* *Delete accordingly***I, ***(insert name)*** confirm my agreement to organ/tissue donation Date: *For more information please 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.Have you given blood in the last 3 years **YES/NO\*** If yes please give date: I, ***(insert name)***  confirm my agreement to be included on the NHS Blood Donor RegisterDate: *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 overleaf): …………………………………………………………………………………………………………………………………………………………………………………………………………………………………**Date of Completion of Form by patient:** **Please email completed form to: SWLCCG.stpcadmin@nhs.net****Alternatively, you may print out and bring it with you to the surgery** |
| **Part 2: To be completed by the doctor****Doctor’s 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 HS CHS list and will provide Child Health Surveillance to this patient❑ I have accepted this patient on behalf of the doctor named below, who is a member of this Practice and is on the HS 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 offices and auditors appointed by the Audit Commission.  Date Authorised General Practitioner Signature (GP) Practice Stamp: ***St Paul’s Cottage Surgery******114 Augustus Road, Wimbledon*** ***London, SW19 6EW*** |
| **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 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:**1. ❑ I understand that I may need to pay for NHS treatment outside of the GP practice.
2. ❑ 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.
3. ❑ 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:  |  |
| 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? | 1. YES: ❑ NO: ❑ | If yes, please enter details from your EHIC or PRC below:  |
| Related image | 2. Country Code:  |  |
| 3. Name |  |
| 4. Given names |  |
| 5. Date of birth |  |
| 6. Personal identification number |  |
| 7. Identification number of the institution |  |
| 8. Identification number of the card |  |
| 9. Expiry date  |  |
| PRC validity period a) From: |  | b) To:  |  |

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 the NHS secondary care (hospitals) and NHS Digital solely for the purpose 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 of Work and Pensions for the purpose of recovering your NHS costs from your home country.  |

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Member of staff receiving form

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**St Paul’s Cottage Surgery**

New Patient Health Questionnaire

Thank you for requesting to register with our practice. In order to complete the registration, please tell us about your health so that we can help you to stay healthy and support you if you have any illnesses or disabilities.

Please complete one form for each family member in their own right and answer **ALL** of the questions to the best of your ability then hand the completed form to a receptionist. Thank you.

Date of completion:

**ABOUT YOU (or the child you are completing this for)**

|  |  |
| --- | --- |
| Title: | First names:  |
| Surname: | Previous surnames: |
| Occupation:  | Date of birth:  |
| Home address:  | Postcode:  |
| Home tel:  | Home tel:  |
| Work tel:  | Email:  |
| Country of birth:  | What is your first language?  |
| Next of kin: (Name, address & tel no): Relationship to you:  |
| Do you need an interpreter when you see a GP or nurse? YES / NO |
| Are you an asylum seeker or refugee? YES / NO  |
| Do you have any special needs that we can help you with? YES / NOPlease say what your needs are  |
| Are you a veteran? YES / NO  |
| What is your ethnic group? **Asian & Asian British**: Pakistani 🗆 / Bangladeshi 🗆 / Indian 🗆 / Chinese 🗆 / other Asian 🗆 **Black & Black British:** Black Caribbean 🗆 / Black African 🗆 / Black other 🗆**White**: British 🗆 / Irish 🗆 / White other 🗆 **Mixed** : White & Black Caribbean 🗆 / White & Black African 🗆 / White & Asian 🗆 / other mixed 🗆  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| Are you a smoker? YES / NO | If no, have you ever smoked? YES / NO  |
| If you currently smoke, what do you smoke? How many a day?  |
| Would you like advice about quitting? YES/NOIf you would like support to quit, call the Wandsworth Stop Smoking Service on 0208 871 5062 |
| How many units of alcohol do you drink in a normal week? (*A unit is a small glass of wine or a half pint of beer*)***Please also complete the alcohol questionnaire at the end of this form.***  |
| Have you ever suffered from or been treated for: |
| High blood pressure YES / NO | COPD (smoking-related lung disease) YES / NO |
| High Cholesterol YES / NO | Thyroid condition YES / NO |
| Heart condition YES / NO | Depression or anxiety YES / NO |
| Stroke or mini-stroke YES / NO | Eczema/hayfever YES / NO |
| Diabetes YES / NO | Asthma YES / NO |
| Cancer YES / NO | Epilepsy YES / NO |
| Blindness/glaucoma YES / NO |  |
| Other mental health conditions YES / NO Please give more details:  |
| Any other medical conditions or operations? YES / NO Please give more details:  |
| Have you been in hospital in the last 2 years? YES / NO If yes, how many times? Please give us some more details if you can:  |
| What medications do you take (include dose if you can): |
| Medication:  | Dose: |
| Medication: | Dose: |
| Medication: | Dose: |
| Medication: | Dose: |
| Medication: | Dose: |
| Medication: | Dose: |
| Are you allergic to any medication? YES / NO If yes, what?  |

**FAMILY HISTORY**

Have any close relatives suffered with the following – state who e.g. father, sister, etc.

|  |  |
| --- | --- |
| Heart disease: Age at onset?  | Diabetes:  |
| High blood pressure:  | Stroke:  |
| High cholesterol:  | Asthma:  |
| Cancer:  | Other:  |

**CARERS**

|  |
| --- |
| Do you have a carer – someone who helps you and who you couldn’t manage without? YES / NO Please give details:  |
| Are you a carer – do you help someone who couldn’t manage without your help, maybe a friend or family member of child with a special need or disability? YES / NO Please give details:  |
| Are you a parent? YES / NO  |  |
| Child name: | Date of birth: |
| Child name: | Date of birth: |
| Child name: | Date of birth: |
| Child name: | Date of birth: |
| Child name: | Date of birth: |
| Child name: | Date of birth: |

**ADULTS ONLY**

Please use the waiting room machine to record the following:

|  |  |
| --- | --- |
| Your weight:  | Your height:  |
| Your blood pressure:  |  |
| We offer chlamydia screening. Please see the information in your new patient pack for more details. If you would like to be contacted for screening tests, please indicate here:  |
| Chlamydia and Gonorrhoea YES/NO (under 25 years only)  |  |

[Click here for information about chlamydia and gonorrhoea](file:///C%3A%5CUsers%5Csbritton%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CK4FB1OOH%5C6.%20Chlamydia%20%26%20Gonorrhoea.docx)

**­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­WOMEN ONLY**

|  |  |
| --- | --- |
| Have you had a cervical smear? YES / NO  | When was the most recent one?  |
| Was it normal? YES / NO  |  |
| Where was it done? (Last GP / private GP /medical / in another country):If your last smear was not done at an NHS GP practice, please provide a copy of the result.  |
| Please tell us if you have had a hysterectomy: YES / NO  |

**CHILDREN ONLY**

If you are completing this form about your child please tell us your name and relationship to this child:

|  |  |  |
| --- | --- | --- |
| Name of mother: | Date of birth: | Registered at this practice? Y / N |
| Name of father: | Date of birth: | Registered at this practice? Y / N |
| Name of guardian: | Date of birth: | Registered at this practice? Y / N |

**IMMUNISATIONS**

We are required to keep information about your child’s immunisations up to date. Please help us by telling us what immunisations your child has had.

If the immunisations were done in another country or by a private clinic in England, then we will need confirmation of the dates.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES / NO** | **Date** | **Place given**  |
| 1st Triple & polio |  |  |  |
| 1st Pneumococcal |  |  |  |
| 1st Rotavirus |  |  |  |
| 1st Men B |  |  |  |
| 2nd Triple & polio |  |  |  |
| 1st Men C |  |  |  |
| 3rd Triple & polio |  |  |  |
| 2nd Pneumococcal |  |  |  |
| 2nd Men B |  |  |  |
| 3rd Men B |  |  |  |
| MMR:  |  |  |  |
| Hib / Men C |  |  |  |
| 3rd Pneumococcal |  |  |  |
| MMR Booster |  |  |  |
| Pre-school booster |  |  |  |
| Tetanus and polio |  |  |  |

**Getting involved and helping us to make our practice the best it can be**

Our patients are of many nationalities, ethnicity groups, ages and interests. We want to hear about your experience of being a patient here and we need your input to help us improve and develop. We often need to ask your opinion and as part of our patient group you would be invited to comment, answer surveys or come to meetings on a specific issue.

Would you like more information about how you could get involved? YES/NO

Would you be interested in joining our patient panel? YES /NO

Would you be prepared to be contacted occasionally about patient surveys? YES/NO

**ALCOHOL**

Alcohol can affect your health and interfere with certain medications and treatments, so it is important that we ask you some questions about your use of alcohol.

Questionnaire below: your answers will remain confidential so please be honest.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Questions** | **0** | **1** | **2** | **3** | **4** | **Score** |
|  | How often do you have a drink containing alcohol? | Never  | Monthly or less | 2-3 times a week | 2-4 times a week | 4 or more times a week  |  |
|  | How many standard drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 or 8 | 10 or more |  |
|  | How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly  | Weekly | Daily or almost daily |  |
|  | How often during the last year have you found that you were not able to stop drinking once you had started  | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
|  | How often during the last year have you failed to do what was expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
|  | How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
|  | How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
|  | How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
|  | Have you or somebody else been injured as a result of your drinking? | No |  | Yes but not in the last year |  | Yes during the last year |  |
|  | Has a relative or a friend or a doctor or health worker been concerned about your drinking or suggested you cut down? | No |  | Yes but not in the last year |  | Yes during the last year |  |

**Thank you for completing this questionnaire.**

**Our health care assistant may contact you to invite you for a health check.**