Cliff Villages Medical Practice
Grantham Road
Navenby
Lincoln
LN5 0JJ

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_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

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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

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New Patient Registration Form

Please complete all pages in full using block capitals

1. Background Details

Contact Details			
NHS Number			
Name		Gender	
Previous Surname (if applicable)			
Address		Date of Birth	
		Home Telephone	
		Work Telephone	
Previous Address			
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Next of Kin	Name: Tel: Relationship:		
Family Registered With Us			
Has the patient been registered in the NHS before? ☐ Yes ☐ No If no please state date entered UK:			

** It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results, health campaigns or Patient Participation Group details*
If you do not consent to being contacted by SMS or Email, please tick here: ☐ SMS ☐ Email

Other Details				
Previous GP	Name: Address:			
Country of Birth				
Ethnicity	☐ White (UK) ☐ White (Irish) ☐ White (Other)	☐ Black Caribbean ☐ Black African ☐ Black Other	☐ Bangladeshi ☐ Indian ☐ Pakistani	☐ Chinese ☐ Other
Religion	☐ C of E ☐ Catholic ☐ Other Christian	☐ Buddhist ☐ Hindu ☐ Muslim	☐ Sikh ☐ Jewish ☐ Jehovah's Witness	☐ No religion ☐ Other:
Housing	☐ Own House ☐ Rented House ☐ Shared House	☐ Nursing Home ☐ Residential Home ☐ Sheltered Home	☐ Homeless ☐ Housebound	☐ Asylum Seeker ☐ Refugee
Employment	☐ Employed ☐ Self-employed	☐ Student ☐ Unemployed	☐ House husband ☐ House wife	☐ Carer ☐ Retired
Overseas Visitor	☐ Yes	☐ European Health Insurance Card Held (please bring details with you)		
Armed Forces	☐ Military Veteran	☐ Family member		
Armed Forces	Date of enlistment:	Date of discharge:		

Communication Needs	
Language	What is your main spoken language? Do you need an interpreter? ☐ Yes ☐ No
Communication	Do you have any communication needs? ☐ Yes ☐ No (If **Yes** please specify below) ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog
Learning disability	Do you have a Learning Disability? ☐ Yes ☐ No (If **Yes** please request a Learning Disability Screening Tool form)

Carer Details				
Are you a carer?	☐ Yes – Informal / Unpaid Carer	☐ Yes – Occupational / Paid Carer		☐ No
Do you **have** a carer?	☐ Yes	Name*:	Tel:	Relationship:

** Only add carer's details if they give their consent to have these details stored on your medical record*

2. Medical History

Medical History

Have you suffered from any of the following conditions?

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Heart Failure	☐ Kidney Disease	☐ Underactive Thyroid
☐ Epilepsy	☐ High Blood Pressure	☐ Stroke	☐ Cancer- Type:

Any other conditions, operations or hospital admission details:

<Problems>
<Summary>

If you are currently under the care of a Hospital or Consultant outside our area, please tell us here:

Family History

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma……..	☐ Heart Disease…….…	☐ Diabetes……..……	☐ Depression……..……
☐ COPD……..….	☐ Stroke…….……..	☐ Kidney Disease..……	☐ Thyroid……..……..
☐ Epilepsy……	☐ Blood Pressure……	☐ Liver Disease..……..	☐ Cancer……..

Other:

<Family History>

Allergies

Please record any allergies or sensitivities below

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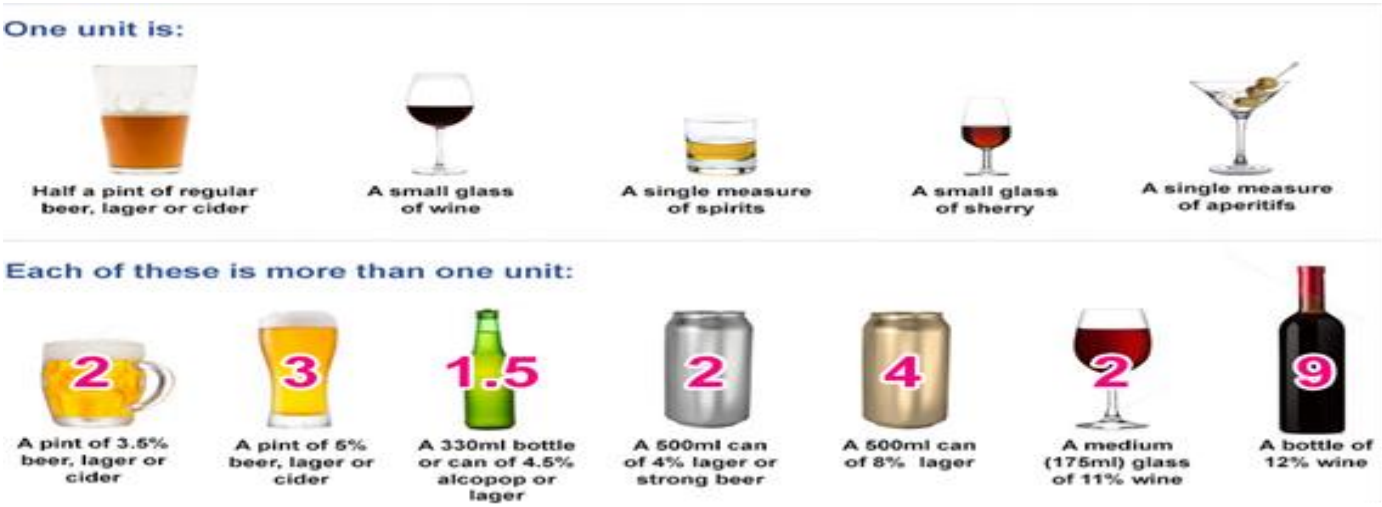
Current Medication
Please check and include as much information about your current medication below Please give us your previous repeat medication list if possible and a medication review appointment may be needed

3. Your Lifestyle

Alcohol

Please answer the following questions which are validated as screening tools for alcohol use:



AUDIT–C QUESTIONS	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL:	

A score of **less than 5** indicates *lower risk drinking*

Scores of 5 or more requires the following 7 questions to be completed:

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AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
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 normally expected from 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 last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in last year		Yes, during last year	
					TOTAL:	

3. Your Lifestyle - Continued

Smoking					
Do you smoke?	☐ Never smoked	☐ Ex-smoker	☐ Yes		
Do you use an e-Cigarette?	☐ No	☐ Ex-User	☐ Yes		
How many cigarettes did/do you smoke a day?	☐ Less than one	☐ 1-9	☐ 10-19	☐ 20-39	☐ 40+
Would you like help to quit smoking?	☐ Yes	☐ No			
	For further information, please see: www.nhs.uk/smokefree				

Height & Weight	
Height	
Weight	
Waist Circumference	

Women Only			
Do you use any contraception?	☐ Yes	☐ No	If needed, please book appointment.
Are you currently pregnant or think you may be?	☐ Yes	☐ No	Expected due date:

Students Only			
Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see www.nhs.uk/Livewell/Studenthealth			
I am less than 24 years old and have had two doses of the MMR Vaccination	☐ Yes	☐ No	☐ Unsure

I am less than 25 years old and have had a Meningitis C Vaccination	☐ Yes	☐ No	☐ Unsure

4. Further Details

Named Accountable GP	
The GP who has overall responsibility for your care is?	<GP Name>

You are however entitled to make an appointment to see any GP of your choice, subject to availability.

Electronic Prescribing	
If you would like your prescriptions to be sent electronically, please provide details of the pharmacy you would like to use:	Pharmacy:

Patient Participation Group	
Would you like to be involved in our Patient Participation Group?	☐ Yes ☐ No

We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.

Blood and Organ Donation	
Blood Donation	☐ I am already a blood donor ☐ I wish to be a blood donor ☐ I do not wish to be a blood donor
Organ Donation	☐ I am already registered as a donor ☐ I wish to be a donor – all body part ☐ I wish to be a donor – for these body parts: ☐ I do not wish to be a donor To register: Online: www.blood.co.uk/the-donation-process/recognising-donors Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card.

Signatures	
Signature	I confirm that the information I have provided is true to the best of my knowledge. ☐ Signed on behalf of patient
Name	
Date	

Checklist

Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed & Signed Above Form
- ☐ Completed & Signed GMS1 Form
- ☐ Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card*
- ☐ Proof of Address *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months*

Practice Use Only

Appointment	☐ Required	☐ Not Required		
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Council Tax	☐ Bank Statement	☐ Other

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5. Sharing Your Health Record

Your Health Record

Do you consent to your GP Practice sharing your health record with other organisations who care for you?

☐ Yes *(recommended option)*
☐ No, never

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ Yes *(recommended option)*
☐ No

Your Summary Care Record (SCR)

Do you consent to having an Enhanced Summary Care Record with Additional Information?

☐ Yes *(recommended option)*
☐ No

Signature

Signature	☐ Signed on behalf of patient
Name	
Date	

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Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

<Organisation Details> will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records
For further information about how the NHS uses your data for research & planning and to opt-out, please see: www.nhs.uk/your-nhs-data-matters

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6. Online Access To Your Health Record

Name

NHS Number

Date of Birth

Address

Telephone

Email Address

I wish to have online access to: *Please tick all that apply*

☐ View & book appointments

☐ View & request medication

☐ Access my coded medical record *(contains any medical codes that have been recorded)*

I wish to access my medical record & understand & agree with each statement: *Please tick all that apply*

☐ I have read and understood the 'Important Information' section below

☐ I will be responsible for the security of the information that I see or download

☐ If I choose to share my information with anyone else, this is at my own risk

☐ I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement

☐ If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

Please bring photographic proof of your identification in order for the sign up process to be completed

Signature	
Signature	
Name	
Date	

For Practice Use Only:

Identity verified through (tick all that apply)	☐ Self Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐ Professional Vouching		
Name of Verifier		Date	
Name of person who authorised and added to SystmOne		Date	
Photocopied this page	☐ Yes – Name:		
Passed for scanning	☐ Yes – Name:		

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Access to GP Online Services

Important Information – Please read before completing form below

If you wish to, you can now use the internet (via computer or mobile app) to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately. If you are unable to do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

During the working day it is sometimes necessary for practice staff to input into your record, for example, to attach a document that has been received, or update your information. Therefore you will notice admin/reception staff names alongside some of your medical information – this is quite normal.

The definition of a full medical record is all the information that is held in a patient's record; this includes letters, documents, and any free text which has been added by practice staff, usually the GP. The coded record is all the information that is in the record in coded form, such as diagnoses, signs and symptoms (such as coughing, headache etc.) but excludes letters, documents and free text.

Before you apply for online access to your record, there are some other things to consider. Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

For further information, please see:
www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx