



Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☐ as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> 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 GP practice while at that address
Address of previous GP practice	

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
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Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:	Postcode
Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)	

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

<input type="checkbox"/> I live more than 1.6km in a straight line from the nearest chemist
<input type="checkbox"/> I would have serious difficulty in getting them from a chemist

*Not all doctors are authorised to dispense medicines

<input type="checkbox"/> Signature of Patient	<input type="checkbox"/> Signature on behalf of patient
Date: ____/____/____	

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Irish Traveller <input type="checkbox"/> Traveller <input type="checkbox"/> Gypsy/Romany <input type="checkbox"/> Polish
<input type="checkbox"/> Any other white background (please write in):
Mixed: <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian
<input type="checkbox"/> Any other Mixed background (please write in):
Asian or Asian British: <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi
<input type="checkbox"/> Any other Asian background (please write in):
Black or Black British: <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Somali <input type="checkbox"/> Nigerian
<input type="checkbox"/> Any other Black background (please write in):
Other ethnic group: <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino
<input type="checkbox"/> Any other ethnic group (please write in):
Not stated: <input type="checkbox"/>

Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only	Patient registered for	<input type="checkbox"/> GMS	<input type="checkbox"/> Dispensing
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To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name

Date

/ /

Practice Stamp

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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 an EU 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: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p>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.</p>	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

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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

Ramsey Health Centre

New Patient Registration Form - Adult

Please complete all pages in full using block capitals

1. Background Details

Contact Details

Surname		Title	
Forename(s)		NHS Number	
Preferred Name		Date of Birth	
Address		Mobile Telephone*	
		Home Telephone	
		Work Telephone	
Email			
Would you like to receive our <u>email</u> newsletter?		<input type="checkbox"/> Yes (please provide email address above) <input type="checkbox"/> No	
Next of Kin	Name:	Tel:	Relationship:

** 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 or health campaigns*

If you do not consent to being contacted by SMS, please tick here: ☐ SMS

Other Details

Ethnicity	<input type="checkbox"/> White (UK)	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Chinese
	<input type="checkbox"/> White (Irish)	<input type="checkbox"/> Black African	<input type="checkbox"/> Indian	<input type="checkbox"/> Other:
	<input type="checkbox"/> White (Other)	<input type="checkbox"/> Black Other	<input type="checkbox"/> Pakistani	
Religion	<input type="checkbox"/> C of E	<input type="checkbox"/> Buddhist	<input type="checkbox"/> Sikh	<input type="checkbox"/> No religion
	<input type="checkbox"/> Catholic	<input type="checkbox"/> Hindu	<input type="checkbox"/> Jewish	<input type="checkbox"/> Other:
	<input type="checkbox"/> Other Christian	<input type="checkbox"/> Muslim	<input type="checkbox"/> Jehovah's witness	
Employment	<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> House husband	<input type="checkbox"/> Carer
	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> House wife	<input type="checkbox"/> Retired

Communication Needs

Language	What is your main spoken language?								
	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Communication / Assistance	Do you have any communication or assistance needs? <input type="checkbox"/> Yes (Please specify below) <input type="checkbox"/> No								
	<table><tr><td><input type="checkbox"/> Hearing aid</td><td><input type="checkbox"/> Large print</td><td><input type="checkbox"/> British Sign Language</td></tr><tr><td><input type="checkbox"/> Lip reading</td><td><input type="checkbox"/> Braille</td><td><input type="checkbox"/> Makaton Sign Language</td></tr><tr><td colspan="3"><input type="checkbox"/> Guide dog</td></tr></table>	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Large print	<input type="checkbox"/> British Sign Language	<input type="checkbox"/> Lip reading	<input type="checkbox"/> Braille	<input type="checkbox"/> Makaton Sign Language	<input type="checkbox"/> Guide dog	
<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Large print	<input type="checkbox"/> British Sign Language							
<input type="checkbox"/> Lip reading	<input type="checkbox"/> Braille	<input type="checkbox"/> Makaton Sign Language							
<input type="checkbox"/> Guide dog									
Disability	Do you consider yourself to have a disability? <input type="checkbox"/> Yes (Please specify below) <input type="checkbox"/> No								

Carer Details

Are you a carer?	<input type="checkbox"/> Yes – Informal / Unpaid Carer <input type="checkbox"/> Yes – Occupational / Paid Carer <input type="checkbox"/> No		
Do you have a carer?	<input type="checkbox"/> Yes	Name*:	Relationship to you:
	<input type="checkbox"/> No	Telephone number/s:	

** 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?

- | | | | |
|-----------------------------------|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Underactive Thyroid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer- Type: |

Any other conditions, operations or hospital admission details:

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

Allergies

Please record any allergies or sensitivities below

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 three questions which are validated as screening tools for alcohol use:

Audit-C Questions	Please mark only one option for each question				
1. 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
2. How many units of alcohol do you drink on a typical day when you are drinking? (see below)	1-2	3-4	5-6	7-9	10+
3. 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

One unit is:



Half a pint of regular beer, lager or cider



A small glass of wine



A single measure of spirits



A small glass of sherry



A single measure of aperitifs

Each of these is more than one unit:



A pint of 3.5% beer, lager or cider



A pint of 5% beer, lager or cider



A 330ml bottle or can of 4.5% alcopop or lager



A 500ml can of 4% lager or strong beer



A 500ml can of 8% lager



A medium (175ml) glass of 11% wine



A bottle of 12% wine

Smoking				
Do you smoke?	<input type="checkbox"/> Never smoked	<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> Yes	
Do you use an e-Cigarette?	<input type="checkbox"/> No	<input type="checkbox"/> Ex-User	<input type="checkbox"/> Yes	
How many cigarettes did/do you smoke a day?	<input type="checkbox"/> Less than one	<input type="checkbox"/> 1-9	<input type="checkbox"/> 10-19	<input type="checkbox"/> 20-39 <input type="checkbox"/> 40+
Would you like an appointment to discuss stopping smoking with the nurse / Healthcare Assistant?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
For further info on quitting, please see: www.nhs.uk/smokefree				

Women Only	
Do you use any contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No If needed, please book appointment.
Do you have a coil or implant in situ?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date inserted:
Are you currently pregnant or think you may be?	<input type="checkbox"/> Yes <input type="checkbox"/> No Expected due date:

4. Further Details

Electronic Prescribing Service (EPS)	
<p>Ramsey Health Centre has a Dispensary for use by those patients who live <u>more than 1 mile from the practice</u></p> <p>If you collect repeat prescriptions from your GP and live <u>less than one mile from the practice</u> then you can choose for us to electronically send your prescription to a pharmacy that is more convenient for you.</p>	<p>Please select your preferred pharmacy from the list. This can be changed at any time.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lloyds Pharmacy, Great Whyte, Ramsey <input type="checkbox"/> Lloyds Pharmacy, Stocking Fen Road, Ramsey <input type="checkbox"/> Wards of Warboys, Warboys <input type="checkbox"/> J.W. Anderson, Somersham <input type="checkbox"/> Tesco In-store Pharmacy, Huntingdon <input type="checkbox"/> Other (please provide name & Address):

Patient Participation and Patient Reference Groups			
<p>Ramsey Health Centre is committed to improving the services we provide. The Patient Participation and Patient Reference Groups are a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.</p> <p>The Patient Participation Group (PPG) meets with the Practice team every 3 months to discuss such matters; however, we appreciate that many of our patients have busy working days, mobility issues, childcare responsibilities etc. and are unable to commit their time to regular meetings. To be truly representative of our entire population we have established a <u>Patient Reference Group (PRG)</u> whom we contact periodically by email so that we can also include your views, opinions and thoughts on our services and enable you to directly influence our delivery.</p> <p>If you would like to have your say and be part of either our PPG or PRG, please indicate your preference below or contact the Practice Manager for more information.</p>			
I would like to join the Patient Reference Group (PRG)	<input type="checkbox"/> Yes <input type="checkbox"/> No	I would like to join the Patient Participation Group (PPG)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Online Access - The NHS App.
<p>Owned and run by the NHS, the NHS App is a simple and secure way to access a range of NHS services on your smartphone or tablet. Use the NHS App to:</p> <ul style="list-style-type: none"> order repeat prescriptions book appointments - search for, book and cancel appointments at your GP surgery, and see details of your upcoming and past appointments get health advice - search trusted NHS information and advice on hundreds of conditions and treatments, and get instant advice or medical help near you view your medical record - securely access your GP medical record, to see information like your allergies and your current and past medicines find out how the NHS uses your data - choose if data from your health records is shared for research and planning <p>The NHS App is available now on iOS and Android. To use it you must be <u>aged 13 and over and registered with a GP surgery in England</u>. You can also access NHS App services on your desktop or laptop computer.</p> <p>For further information and links to the App download please visit: www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app</p>

5. Sharing Your Health Record

Your Health Record

EDSM (Enhanced Data Sharing Model) enables us, with your consent, to share your medical records with those Health Professionals in the NHS who are involved in your care (for example District Nurses, Community Services teams). Only NHS staff can access shared information and being an electronic service an audit log is maintained showing when and who has accessed medical records.

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

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

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

- ☐ Yes (*recommended option*)
☐ No

Summary Care Record (SCR)

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. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health. **If you do not want a Summary Care Record, please opt-out and sign below.**

☐ I **DO NOT** want a Summary Care Record

With your consent, additional information can be added to create an **Enhanced Summary Care Record**. This could include your illnesses and health problems, any previous vaccinations, as well as any care plans, which will help ensure that you receive the appropriate care in the future.

☐ I consent to having an **Enhanced** Summary Care Record with Additional Information (*recommended option*)

Signature

Signature	I confirm that the information I have provided is true to the best of my knowledge.		
 <input type="checkbox"/> Signed on behalf of patient (Please provide relationship to patient)		
Name		Date	

Checklist

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

- ☐ NHS Number (this can be obtained from your previous GP, NHS Numbers are made up of 10 numbers) If you have never used an NHS service you will not have an NHS number, in this case we require the date you first arrived in the UK as well as your first UK address (complete on GMS1)
- ☐ Completed and Signed Above Form
- ☐ Completed and Signed GMS1 Form (Purple form)

FOR STAFF USE ONLY (Patient Services - Please date and initial)

GIVEN BY:	RECEIVED BY:	<input type="checkbox"/> New Patient Check offered	<input type="checkbox"/> Booked..... <input type="checkbox"/> Declined / <input type="checkbox"/> Unable to book
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