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

Mobile 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

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood 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 CHSlist 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

Printed by THE ASTRON GROUP, 03/02, J01E0463

New Patient Check Form (Amended April 2018)

(please bring 2 forms of identification with you when dropping these forms off, including one photographic ID)

Staff only: #67DJ

Name: _____Date of Birth: _____

Telephone number (House):_____ (Mobile):_____

Address: _____

Email Address: _____

We are now required to ask for consent before contacting you via SMS text and e-mail messages please can you tick to confirm consent Yes ( ) No ( )
(staff only: Yes #9NdP No #9NdQ)

Occupation: _____ Today's Date: _____

Height: _____ Weight: _____

Name and contact number of next of kin: _____

Main language spoken if NOT English:_____

Please tick here if you are currently serving, or have ever served, in the UK Armed Forces (this includes reservists or part-time service e.g. Territorial Army) ☐ 13JI

Please tick here if you are a member of a current or former serviceman or woman's immediate family/household ☐ 13WY

Ethnic Category Code (Please tick)

White			
A	British	☐	| 9i0
C	Any other White background	☐	| 9i2
B	Irish	☐	| 9i1
Mixed			
D	White and Black Caribbean	☐	| 9i3
E	White and Black African	☐	| 9i4
F	White and Asian	☐	| 9i5
G	Any other mixed background	☐	| 9i6
Asian or Asian British			
H	Indian	☐	| 9i7
J	Pakistani	☐	| 9i8
K	Bangladeshi	☐	| 9i9
L	Any other Asian background	☐	| 9iA
Black or Black British			
M	Caribbean	☐	| 9iB
N	African	☐	| 9iC
P	Any other Black background	☐	| 9iD
Other Ethnic Groups			
R	Chinese	☐	| 9iE
S	Any other ethnic group	☐	| 9iF
Z	Not stated	☐	I 9iG

COMMUNICATION

Is there anything we need to know about you in order to help us communicate with you e.g. hearing impairment:…….....
…….

Is there something that we can do practically to help us communicate with you better e.g. form or method of communication or print size. …….
……...

Do you need anyone to help you communicate with us e.g. interpreter or advocate?
……

SMOKING

1. Do You Smoke: Yes No ☐ (**If no see section 2**)
   If yes do you **S**moke: **C**igarettes ☐ Ci**G**ars ☐ **P**ipe ☐ **R**oll-ups ☐
   How many ounces or cigarettes a day? _____
   How many years have you smoked for? _____
   Would you like information on how to refer yourself to the Eastbourne Stop Smoking Team? Yes ☐ No ☐
   Leaflet on back page.

2. Are you an **E**x smoker: Yes ☐ No ☐ (**If no see section 3)**
   If yes how many years did you smoke for? _____ How long ago did you stop?
   What did you smoke: **C**igarettes ☐ **C**igars ☐ **P**ipe ☐ **R**oll-ups ☐
   How many ounces or cigarettes a day _____

3. Are you a **P**assive smoker Yes ☐ No ☐ (**if no see section 4)**
4. Are you a life long non smoker? Yes ☐ No ☐

CARERS

Are you a carer Yes ☐ No ☐ **i**f yes, please can we have the name of the person you care for: …….
and what is your relationship?……

'Care for the carers' are available to help you on: 01323 738390. www.cftc.org.uk

A carer is a person who looks after someone at home because of their relationship with that person. A carer may be a relative / friend or neighbour and does not always live with the person cared for. A carer is not paid for the care they provide.

Please feel free to ask for an appointment with our Health Care Assistant, Practice Nurse or GP for a 'Health check' to take your Blood Pressure, Weight, Height, test your urine and take a brief medical history.

MEDICAL RECORDS

We will apply for your medical records on the day you register with us, however, you need to allow approximately 6-8 weeks for them to arrive and up to a maximum of 8 weeks for us to process them. It is therefore essential that any important medical conditions are disclosed on this form.

FEMALES

If over the age of 50 have you attended for breast screening examination? Yes ☐ No ☐

PAST ILLNESSES

Please list any serious illnesses/operations/accidents etc.

YEAR	ILLNESS ETC

ALLERGIES

If you have had any allergies to drugs, food or injections please list them and what happened……
……
……

MEDICATION
Please list any medication that you are taking, including the amount you take each day.

NAME OF DRUG	DOSE & HOW OFTEN TAKEN	MEDICAL CONDITION

You will need to book a telephone appointment with your doctor for your first prescription. Please allow plenty of time before your medication runs out.

ELECTRONIC PRESCRIBING
We are in the process of moving to electronic prescribing. This will enable us to send your prescription electronically to a chemist of your choice.

If you would like us to arrange this for you please sign here:_____.

If you have a chemist in mind that you would like to use please provide us with the name:_____.

CONTACTING YOU
We may need to contact you by post, telephone or Email. By supplying your Email address you are agreeing to be notified of our online appointment service. Sometimes we may leave a message on your answer phone for you to contact us. If you have any objections to the above please inform the practice in writing.
Important information about our surgery can be found on our website
www.stonecrosssurgery.co.uk

The Summary Care Record

The Summary Care Record is a copy of key information from your GP record. The Summary Care Record provides authorised care professionals working elsewhere in the NHS with faster, secure access to essential information about you when you need care.

All patients will have a **core Summary Care Record** unless they have previously informed their GP practice that they didn't want one. A **core Summary Care Record** includes details of the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past.

We would now like to offer you the opportunity to allow **additional information** to be added to your Summary Care Record including significant medical history, illness and operations (past and present), reasons for medications, and care plan information (if any).

If you would like to have an SCR with Additional Information please tick here.	
If you no longer wish to have a SCR, please ask at reception for an opt-out form	

Over 16's Alcohol Questionnaire – Please Complete Section 1

Name:…… Date of birth:……..
Date: …….

1	Using the above chart, how many units do you have per week?	

	Scoring System					
	Questions	0	1	2	3	4	Your Score
2	How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
3	How many standard alcoholic drinks do you have on a typical day when drinking?	1-2	3-4	5-6	7-8	10+	
4	How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scored 5 or more? – Please complete questions 5-11 (Audit)

Total (Q 2-4)	

Alcohol Users Disorders Identification Test (AUDIT)

	Scoring System					
	Questions	0	1	2	3	4	Your Score
5	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
11	Has a relative/friend/doctor/ health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total (Q2-11)	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence
By completing this form you may be contacted by an alcohol support worker.
For Staff: Scored over 8 and not seen a Clinician put message in grey bubble and send to Julie

APPOINTMENTS

In order to book you with the most appropriate person (Nurse/Doctor/Health Care Assistant/Nurse Practitioner/Nurse Specialist/Phlebotomist) and for the correct amount of time (10/20/30 minutes) our receptionists are trained to ask you if you are willing to give them an indication of the problem when you telephone us for an appointment. This is completely confidential and we have very strict policies on confidentiality. However, if you do not wish to tell them you can just say I would rather not, or that it is personal. This is perfectly acceptable and you will not be questioned further.

We do not ask patients who we are dealing with face to face as we can sometimes be overheard by other patient's queuing, however, if the complaint is not confidential please feel free to tell the receptionist as this will help her book you with the most suitable person.

If you have any questions/concerns regarding this please do not hesitate to contact the Practice Manager on 761461.

FAMILY HISTORY – serious illness and death only

	Age of diagnosis if known.	Serious illness, heart, diabetes, stroke, cancer, etc	Age at death	Cause of death if known
FATHER				
MOTHER				
BROTHER				
SISTER				

FOR FEMALES ONLY

Date of last smear: …… (Approx).

If appropriate, name/type of contraception:……

Have you had a hysterectomy? Yes ☐ No ☐ If yes:
Was your cervix removed when you had the hysterectomy? Yes ☐ No ☐

CONSENT (Over 16's)

Due to data protection, we will only give results and other medical information to the patient. If you would like someone else to be able to access your medical information, results etc, on your behalf, please complete the following:

DATE: ……

NAME: …… DOB: …….

authorise ……..

to obtain medical results or information about myself both previous to me signing this form and future medical results or information from Stone Cross, Pevensey Bay and Westham surgeries.

Signed ……

This document will be stored in your medical records.

Please detach this sheet and keep for your records.

Stone Cross Stop Smoking

If you would like help to stop smoking please telephone ONE YOU East Sussex on 01323 404600
Or email hello@oneyoueastsussex.org.uk or visit their website for more information
www.oneyoueastsussex.org.uk

The Benefits of Stopping Smoking

Stopping smoking can make a big difference to your health and lifestyle. It is never too late to stop smoking to greatly benefit your health. For example, if you stop smoking in middle age, before having cancer or some other serious disease, you avoid most of the increased risk of death due to smoking. Help is available if you find it difficult to stop smoking.

What are the health benefits of stopping smoking?

The benefits begin straight away.

You reduce your risk of getting serious disease no matter what age you give up. However, the sooner you stop, the greater the reduction in your risk.

- If you stop smoking you:
  - Reduce the risk of getting serious smoking-related diseases such as heart disease, cancers, COPD (chronic obstructive pulmonary disease) and peripheral vascular disease.
  - Reduce the risk of getting various other conditions which, although not life threatening, can cause unpleasant problems. For example: impotence (erection problems), fertility problems, optic neuropathy, cataract, macular degeneration, psoriasis, gum disease, tooth loss, osteoporosis and Raynaud's phenomenon.
  - Reduce the risk of pregnancy complications if you are pregnant.
- If you have smoked since being a teenager or young adult:
  - If you stop smoking before the age of about 35, your life expectancy is only slightly less than people who have never smoked.
  - If you stop smoking before the age of 50, you decrease the risk of dying from smoking-related diseases by 50%.
- But it is never too late to stop smoking to gain health benefits. Even if you already have COPD or heart disease, your outlook (prognosis) is much improved if you stop smoking.

Timeline of health benefits after stopping smoking...

After...	Health Benefit...
72 hours	Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase
1 month	Skin appearance improves owing to improved skin perfusion
3-9 months	Cough, wheezing, and breathing problems improve and lung function increases by up to 10%
1 year	Risk of a heart attack falls to about half that of a smoker
10 years	Risk of lung cancer falls to about half that of a smoker
15 years	Risk of heart attack falls to the same level as someone who has never smoked

Other benefits of stopping smoking include:

- Your breath wont smell any more of stale tobacco.
- The smell of stale tobacco will also go from your clothes, hair, and home.
- Foods and drinks taste and smell much better.
- Finances improve. You will save well over £1000 per year if you smoked 20 a day.
- Better rates of insurance policies.
- You are likely to feel good about yourself.

How can I stop smoking?

About 2 in 3 smokers want to stop smoking. Some people can give up easily. Willpower and determination are the most important aspects when giving up smoking. However, nicotine is a drug of addiction and many people find giving up a struggle. Help is available.

- Various medicines can increase your chance of quitting. These include Nicotine Replacement Therapy (NRT) which comes as gums, sprays, patches, tablets, lozenges, and inhalers. You can buy NRT without a prescription. Also, medicines called bupropion (trade name 'Zyban') and varenicline (trade name 'Champix) can help. These are available on prescription. See separate leaflets called '*Smoking - Nicotine Replacement Therapy*', '*Smoking - Helping to Stop with Bupropion*' and '*Smoking - Helping to Stop with Varenicline*'.

References

- Smoking cessation, Clinical Knowledge Summaries (April 2008)
- Smoking cessation, NICE (2006)
- Various factsheets and guidelines on smoking and smoking cessation, Action on Smoking and Health (various dates)