# 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

# NHS 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 |
| *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.* | | |
| PRC validity period (a) From: | DD MM YYYY | (b) To: 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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Do you have any special communication needs? □ Yes □ No
If yes: □ Sign Language □ Large Print □ Other ……

# Welcome to College Surgery Partnership

Please help us by filling some personal details. **This information is treated in confidence.**

Have you ever been registered at any of the College Surgery sites (incl Sampford Peverell) YES ☐ NO ☐

**FULL NAME** _____ **DATE OF BIRTH:** _____

**ADDRESS:**

_____ **POSTCODE**

**CONTACT NUMBERS:**

HOME: _____ MOBILE: _____ WORK

Please indicate which number you would prefer to be contacted on ☐

e-mail Address _____

**Please note by giving your e-mail address you are consenting to receive confidential information (such as reset passwords) to this address**

**MARITAL STATUS:**

| | | | | | |
|---|---|---|---|---|---|
| SINGLE | ☐ | MARRIED | ☐ | WIDOWED | ☐ |
| DIVORCED | ☐ | SEPARATED | ☐ | L/T RELATIONSHIP | ☐ |

**NAME, RELATIONSHIP & CONTACT NUMBER OF NEXT OF KIN:**

DO YOU HAVE CHILDREN YES ☐ NO ☐

NAMES & DATES OF BIRTH OF CHILDREN: _____

**ETHNICITY:**

| | | | | | |
|---|---|---|---|---|---|
| WHITE BRITISH | ☐ | IRISH | ☐ | OTHER WHITE | ☐ |
| WTE/BLK CARIB | ☐ | WTE/BLK AFRICAN | ☐ | WHITE/ASIAN | ☐ |
| OTHER MIXED | ☐ | INDIAN | ☐ | PAKISTANI | ☐ |
| BANGLADESHI | ☐ | OTHER ASIAN | ☐ | BLACK BRITISH | ☐ |
| BLK CARIBBEAN | ☐ | BLACK AFRICAN | ☐ | OTHER BLACK | ☐ |
| OTHER ETHNIC | ☐ | CHINESE | ☐ | PREFER NOT TO SAY | ☐ |

OCCUPATION (If retired please give previous) ☐

**MAIN SPOKEN LANGUAGE**

IF YOUR MAIN SPOKEN LANGUAGE IS NOT ENGLISH, DO YOU SPEAK ENGLISH YES/NO

ARE YOU ARE CARER YES NO

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this support.

DO YOU HAVE A CARER YES NO

If your carer is also a patient of College Surgery, please provide their name and address:

**ALLERGIES**

| | | | | | | |
|---|---|---|---|---|---|---|
| DRUG ALLERGY | | | OTHER ALLERGY (pets/pollen) | | | |

**MEDICAL HISTORY (Please include dates if possible)**

| | | | | | | |
|---|---|---|---|---|---|---|
| OPERATIONS | | | TB/HEPATITIS/SERIOUS INFECTION | | | |
| | | | EPILEPSY | | | |
| STROKE | | | MENTAL HEALTH PROBLEMS | | | |
| HEART DISEASE | | | ARTHRITIS | | | |
| DIABETES | | | BACK PAIN | | | |
| HIGH BLOOD PRESSURE | | | KIDNEY DISEASE | | | |
| ASTHMA | | | COPD (bronchitis/emphysema) | | | |
| CANCER | | | OTHER | | | |

**FAMILY HISTORY OF PARENT,BROTHER OR SISTER**

| | Family Member | | Age Diagnosed (if known) | | | If deceased age at death | |
|---|---|---|---|---|---|---|---|
| DIABETES | | | | | | | |
| HEART DISEASE | | | | | | | |
| HIGH BLOOD PRESSURE | | | | | | | |
| STROKE | | | | | | | |
| EPILEPSY | | | | | | | |
| CANCER (specify) | | | | | | | |
| GLAUCOMA | | | | | | | |
| ASTHMA | | | | | | | |
| OTHER | | | | | | | |

**MEDICATIONS - Please attach repeat prescription list (If repeat list not available please state drug name, strength and dosage)**

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

**If you take regular medication please ask for an appointment to see your new Doctor before your next prescription is due**

**LIFESTYLE:**

DO YOU SMOKE YES NO EX-SMOKER

IF CURRENT SMOKER HOW MANY A DAY DO YOU SMOKE

WOULD YOU LIKE TO BE REFERRED FOR HELP TO STOP SMOKING YES NO

YOU MAY CONTACT DEVON STOP SMOKING TEAM DIRECT ON (01884) 836024

EX SMOKERS -

HOW LONG DID YOU SMOKE

HOW MANY A DAY DID YOU SMOKE

DATE YOU STOPPED SMOKING

ALCOHOL - please complete attached questionnaire

HEIGHT WEIGHT

**FEMALES ONLY**

HAVE YOU EVER HAD A CERVICAL SMEAR YES NO

IF YES PLEASE ADVISE LAST TEST AND RESULT

WHAT FORM OF CONTRACEPTIVE DO YOU USE

NONE ORAL COIL CONDOM

INJECTION IMPLANT OTHER

ANY OTHER INFORMATION YOU FEEL WOULD ASSIST YOUR DOCTOR

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If you would like a New Patient Health Check please ask at reception

SIGNED DATE

How did you hear of us - please tick all that apply INTERNET OUR WEBSITE

NHS Choices LOCAL INFORMATION PERSONAL RECOMMENDATION

NEWSLETTER / PARISH MAGAZINE OTHER (Please specify)

**NAME** **DATE OF BIRTH**


## Alcohol Users Disorders Identification Test (AUDIT)

| 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 | |
| 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 the last year | | Yes, during the 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 the last year | | Yes, during the last year | |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

16 – 19 Higher risk, 20+ Possible dependence

| |
|---|
| Your Name: |
| Date of Birth: |
| NHS no. (if known) |

Northern, Eastern and Western Devon Clinical Commissioning Group

Do you have any special communication needs?

☐ Yes ☐ No

If yes:

☐ Sign Language ☐ Large Print ☐ Other…….


College Surgery offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

## What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications, and**
- **any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree (explicit consent).

## Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

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- Please complete and return this form to the receptionist

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**Please tick the box and sign below:**

I do want a Summary Care Record ☐

I do not want a Summary Care Record ☐

Signed: _____ Date: _____

**For more information visit www.nhscarerecords.nhs.uk or call 0300 123 3020.**

## College Surgery Partnership

July 2016

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……

### ELECTRONIC SHARING OF MEDICAL INFORMATION

Today, electronic records are kept in all the places where you receive healthcare. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down your treatment and mean information is hard to access.

College Surgery Partnership, however, uses a unique computer system, systmone ONEPATIENTONERECORD , (SystmOne) that allows the sharing of full electronic records across different healthcare services.

We are telling you about this so you can consider your choices.

- You can choose to share your electronic record with other care services
- You can choose NOT to share your electronic record with other care services

### How is my decision recorded?

SystmOne has two settings to allow you to control how your medical information is shared:

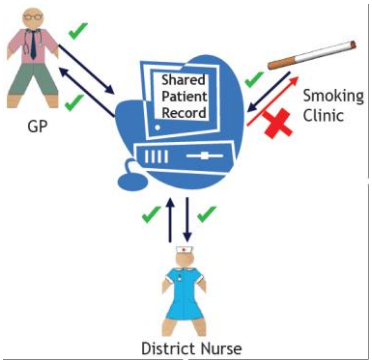
1. **Sharing OUT**
   **This controls whether your information entered at College Surgery Partnership can be shared with other NHS services.**
2. **Sharing IN**
   **This controls whether information that has been made shareable at other NHS care services can be viewed by College Surgery Partnership.**

## How does this work?

Imagine you're receiving care from 3 different NHS services: your GP, a District Nurse and a smoking clinic. You want your GP and nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However you don't want the smoking clinic to see any of your other medical information.

Your sharing settings would be:

The GP can share information **IN and OUT**. The District Nurse can share **IN and OUT**. The smoking clinic can only share information **OUT BUT NOT IN**.




If you are a new or returning patient with College Surgery Partnership, you will be asked to state your electronic record sharing preferences as part of our registration process.
For existing patients with College Surgery Partnership your electronic record will already have our system default settings which are:

- **Share information in from other NHS service providers (sharing IN enabled).**
- **Do not share information with other NHS service providers (sharing OUT disabled).**

If you wish to review or change your electronic record sharing options, please write to us or complete and return the following tear off slip.

==========✂==========

Please amend my electronic record sharing preferences as specified below:

| | Enabled | Disabled |
|---|---|---|
| **Share information in from other NHS service providers (Sharing IN)** | | |
| ***Please tick box required*** | ☐ | ☐ |
| **Share information with other NHS service providers (Sharing OUT)** | **Enabled** | **Disabled** |
| ***Please tick box required*** | ☐ | ☐ |

Print Name:……Date of Birth……

Signed:……..Date:……

Jul - 16

# Application for online access to my medical record (Patients over 16 only)

| | |
|---|---|
| Surname | Date of birth |
| First names | |
| Address<br><br>Postcode | |
| Email address | |
| **Please note by giving your e-mail address you are consenting to receive confidential information (such as reset passwords) to this address.** | |
| Telephone number | Mobile number |
| If you would like to receive SMS text messages please tick here ☐ | |

I wish to have access to the following online services (please tick all that apply):

| | |
|---|---|
| 1. Booking appointments (N/A for existing online patients) | ☐ |
| 2. Requesting repeat prescriptions (N/A for existing online patients) | ☐ |
| Please state preferred collection point for prescriptions: _____ (i.e. surgery or name of chemist) | |
| 3. Access to a summary view of my medical record | ☐ |
| 4. Access to a more detailed view of my medical record | ☐ |

If you have requested access to your medical record, please confirm you understand and agree with the following (tick):

| | |
|---|---|
| 1. I have read and understood the information leaflet provided by the practice | ☐ |
| 2. I will be responsible for the security of the information that I see or download | ☐ |
| 3. If I choose to share my information with anyone else, this is at my own risk | ☐ |
| 4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | ☐ |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | ☐ |

Please note that online services can only be processed upon receipt of 2 forms of ID, one with a photograph of yourself and one with proof of your home address.

| | |
|---|---|
| I understand it is my responsibility to provide the surgery with any change of contact details (address, telephone number, e-mail address)<br><br>Signature | Date |

**For practice use only**

| | | | |
|---|---|---|---|
| Evidence of identity seen | Date | Method: Photo ID (e.g. Passport) and proof of residence ☐ | |
| Authorised by registered or usual GP (signature) | | | Date |
| Date account created | | | |
| Date access confirmation and password details sent | | | |
| Level of record access enabled<br>Basic Summary View ☐<br>Prospective ☐ | | | Notes |

College Surgery Partnership:

CVCIH Cullompton (01884) 831300
Millway, Bradninch (01392) 881952
Lower Town, Sampford Peverell (01884) 820304
Grantlands, Uffculme (01884) 840743
South View Close Willand (01884) 821878

# Online Services Records Access
# Patient information leaflet 'It's your choice'

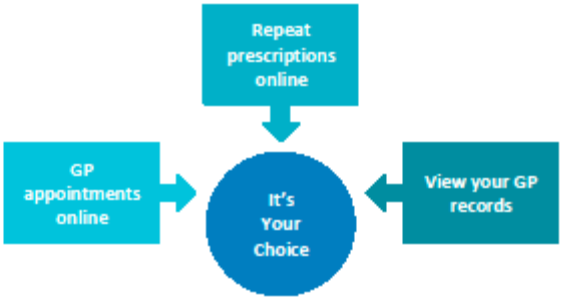
If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well (except repeat prescription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

Being able to see your record online might help you to manage your medical conditions. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

To obtain access to online services all patients will be required to complete an application form and provide photographic proof of identity and evidence of address.

Unless you are already registered for online services you will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

**The practice has the right to remove online access to services for anyone that doesn't use them responsibly.**




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 can't 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.

Due to the complexities with consent we are, regrettably, unable to offer online services to patients under the age of 16.

# 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.

## Things to consider

### 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.

### More information

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:

Keeping your online health and social care records safe and secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf

**FOR OFFICE USE:** Processed – Intls & Date

# THE PATIENTS' GROUP AT COLLEGE SURGERY PARTNERSHIP NEEDS YOUR VIEWS!

Would you like to have a say about the services provided at College Surgery Partnership? If so the Patients' Group would like to hear from you.

By leaving your email details we can contact you to ask a few questions from time to time.

If you are happy for the Patients' Group to contact you periodically by email please complete your details below and hand this form back to reception, a Patients' Group representative, post in the secure post box by reception in Cullompton, or email as an attachment to *patientsgroup@collegesurgery.org.uk*.

---

Name:……..

Email address:……

Postcode:……..

How would you describe how often you come to the practice?

Please tick (√)

Regularly ☐ Occasionally ☐ Very rarely ☐

We would welcome any comments and suggestions you may have on the service provided by the practice so please e-mail any feedback to: *patientsgroup@collegesurgery.org.uk or text to 07745 553182.* ***Please do not use the e-mail address to contact us about any clinical or health need you have.***

*The information you supply us with will be used lawfully, in accordance with Data Protection Act 1988. The Data Protection Act 1988 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.*