**The Nuffield Practice**

**General Medical Practitioner (GMS1)**

Application to register with a General Medical Practitioner

Please help us by completing the following information. This is very important as it may take some weeks for your medical records to arrive.

**Patient's Details - Please complete the text boxes and tick where appropriate.**

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| Title: | Surname: |
| First Name(s): | Forenames: |
| Previous Surname: | What do you prefer to be called? |
| Sex: | Marital status: |
| Date of Birth (Day/Month/Year):Birth Town:Birth Country: NHS No.:  | Home Address:Postcode: |
| \*Do you consent to us contacting you by email using the address given below to send you health information and practice news? **Yes [ ] No [ ]** |
| Email address: |
| **Telephone numbers:**Please remember to let us know if your contact details change in case, we need to contact you urgently.\*Do you consent to us contacting you including by text, using the mobile phone number given above or your home phone to ask you to make appointments or remind you of appointments made or to send you information about the practice? **Yes [ ] No [ ]** |
| Home: | Work: | Mobile: |
| **Please help us trace your previous medical records by providing the following.** |
| Name of previous GP while at previous address: |  |

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| Your previous address in UK: |  |
| Address of that Doctor: |  |
| **If you are from abroad** |  |
| Your first UK address where registered with a GP: |  |
| If previously resident in UK, date of leaving (DD/MM/YYYY): |
| **If you are returning from the armed forces** |
| Address before enlisting:Service or Enlistment Personnel number:Enlistment date (DD/MM/YYYY): |
| If you are registering a child under 5: I wish the child above to be registered with the named doctor for Child Health Surveillance **[ ]**If you need your doctor to dispense medicines and appliances: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 **[ ]***\*Note: all doctors are authorised to dispense medicines* |
| Signature of patient:Date (DD/MM/YYYY): | Signature on behalf of patient:Date (DD/MM/YYYY): |
| **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 (DD/MM/YYYY): |

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| 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 (DD/MM/YYYY): |
| 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) |
| Address:Postcode: |  |
| **HA use only** |  |
| Patient registered for:GMS **[ ]** CHS **[ ]** Dispensing **[ ]** Rural Practice **[ ]** |
| **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: |
| 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. **[ ]**HA Code: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: | Practice stamp: |
| Name: | Date: (DD/MM/YYYY): |

**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:

**[ ]** I understand that I may need to pay for NHS treatment outside of the GP practice

**[ ]** 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

**[ ]** 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:

Print name:

On behalf of:

Date (DD/MM/YYYY):

Relationship to patient:

**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 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.

If yes, please enter details from your EHIC or PRC below:

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| Country Code (e.g. UK, DE etc.): |
| Name:Given Names: | Date of Birth (DD/MM/YYYY): |
| Personal Identification Number:Identification number of the institution:Identification number of the card:Expiry Date (DD/MM/YYYY): | 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.

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| Occupation: |
| I am a student at: |
| **How often do you exercise?** |
| Times a week or not much: | Your height:Your weight:Your blood pressure: |

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| Do you smoke? **Yes [ ] No [ ]**I have never smoked. **Yes [ ] No [ ]** | How many cigarettes a day:How many years ago did you give up smoking? |
| Would you like to give up smoking? Help and treatment is available here. Ask at reception. |

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| **Next of kin:** |
| Name:Telephone number:Relationship: | Address:Post code: |

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| Are you a carer: **Yes [ ] No [ ]**Are you in receipt of Carer’s allowance? **Yes [ ] No [ ]** | Relationship to you:Name of person you are caring for: |
| Have any members of your immediate family (parents, brother, sister) had any of the following:Ischaemic heart disease when less than 60 years: : **[ ]** |
| When over 60 years: : **[ ]** | Breast cancer: : **[ ]** |
| Depression: : **[ ]** | Stroke: : **[ ]** |
| Diabetes: : **[ ]** | Thyroid problem: : **[ ]** |
| **If you are on any regular medication, please bring in a repeat prescription slip from your old practice, listing your medication, so that we can put it on the computer. Otherwise, you will have to have an appointment with the doctor before we can give you a prescription. Please allow plenty of time for your prescription to be prepared: we need at least 2 working days for your prescription to be authorised and sent to the pharmacy (and the Pharmacies need another 2 working days for dispensing.)**Which pharmacy would you like your repeat prescription to be sent to?Rowlands Pharmacy: **[ ]**Boots the Chemists: **[ ]**Sainsbury’s Pharmacy: **[ ]**Lloyds Pharmacy: **[ ]**Your local Boot’s Pharmacy (Deer Park) : **[ ]**Postal Services: Quantum Pharmaceutical Solutions Ltd: **[ ]**Pharmacy2U: **[ ]** |

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| **If you have a Dossett Box then please ensure you have adequate medication as it can take 6 weeks to organise.****Do you have any allergies to any medicines or substances on your skin?** |
| Name of medicine or substance:Are you a veteran? **Yes [ ] No [ ]** | What problem does it cause? |
| **Ethnicity:****Please tick the ethnic group which you feel most accurately describes you. These are National codes as defined by the 2001 Census.** |
| **White British:** British **[ ]** Irish **[ ]**  | **Other ethnic groups:**Chinese **[ ]** Any other ethnic group **[ ]** Not stated **[ ]**  |
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| Any other White background:**Mixed:**White and Black Caribbean **[ ]** White and Black African **[ ]** White and Asian **[ ]** Any other mixed background:**Black or Black British:**Caribbean **[ ]**African **[ ]**Any other Black background: |  | **Asian or British Asian:**Indian **[ ]** Pakistani **[ ]** Bangladeshi **[ ]** Any other Asian background: |
| **Language:****What is your first language? Please tick. For babies and children please tick the language of their parents**My first language is: |
| Akan (Ashanti) **[ ]**Albanian **[ ]**Amharic **[ ]**Arabic **[ ]**Bengali & Sylheti **[ ]**Brawa & Somali **[ ]**British Signing Language **[ ]**Cantonese **[ ]**Cantonese and Vietnamese **[ ]**Creole **[ ]**Dutch **[ ]**English **[ ]**Ethiopian **[ ]**Farsi (Persian) **[ ]**Finnish **[ ]**Flemish **[ ]** | French **[ ]**French creole **[ ]**Gaelic **[ ]**German **[ ]**Greek **[ ]**Gujarati **[ ]**Hakka **[ ]**Hausa **[ ]**Hebrew **[ ]**Hindi **[ ]**Igbo (Ibo) **[ ]**Italian **[ ]**Japanese **[ ]**Korean **[ ]** | Kurdish **[ ]**Lingala **[ ]**Luganda **[ ]**Makaton (sign language) **[ ]**Malayalam **[ ]**Mandarin **[ ]**Norwegian **[ ]**Pashto (Pushtoo) **[ ]**Patois **[ ]**Polish **[ ]**Portuguese **[ ]**Punjabi **[ ]**Russian **[ ]**Serbian/Croatian **[ ]**Sinhala **[ ]** | Somali **[ ]**Spanish **[ ]**Swahili **[ ]**Swedish **[ ]**Sylheti **[ ]**Tagalog (Filipino) **[ ]**Tamil **[ ]**Thai **[ ]**Tigrinya **[ ]**Turkish **[ ]**Urdu **[ ]**Vietnamese **[ ]**Welsh **[ ]**Yoruba **[ ]** |
| Other: |
| **If you are 16 or over, please complete the following questions****Questions:** |
| How often do you have 8 (men) or 6 (women) or more drinks on one occasion? |
| Never (score 0) **[ ]**Less than monthly (score 1) **[ ]**Daily or almost daily (score 4) **[ ]** | Monthly (score 2) **[ ]**Weekly (score 3) **[ ]** |
| **Only answer the following questions if your score is 2 or more**How often in the last year have you not been able to remember what happened when drinking the night before? |
| Never (score 0) **[ ]**Less than monthly (score 1) **[ ]**Daily or almost daily (score 4) **[ ]** | Monthly (score 2) **[ ]**Weekly (score 3) **[ ]** |
| How often in the last year have you failed to do what was expected of you because of your drinking? |
| Never (score 0) **[ ]**Less than monthly (score 1) **[ ]**Daily or almost daily (score 4) **[ ]** | Monthly (score 2) **[ ]**Weekly (score 3) **[ ]** |
| 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 **[ ]** |
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| **Scoring: a total of 3 or above indicates hazardous or harmful drinking.****If you scored 3 or more and are interested in finding out a bit more, please ask the receptionist for the longer alcohol audit questionnaire and leaflet.****Practice use only:** |
| Extra questionnaire and leaflet given: |