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*

☐ 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

**Not all doctors are authorised to dispense medicines*

☐ **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**

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:
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.	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	(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.

Thornfield Medical Group

Partners: Dr NA Crowe, Dr RP Gray, Dr ID Jackson, Dr C Watson, Mrs T Stuchlik
Tel: 0191 275 5740 **Email**: NGCCG.thornfieldmedical@nhs.net

Molineux Street NHS Centre
Byker
Newcastle upon Tyne
NE6 1SG

Shieldfield Health Centre
Stoddart Street
Newcastle upon Tyne
NE2 1AL

Dear Patient,

We would like to welcome to you to Thornfield Medical Group and take this opportunity to explain our services.

In order for the practice to provide you with a quality service we need you to provide us with some crucial information. It is important that we ask all new patients to provide identification and proof of address upon registering.

We require two forms of ID, one photographic and one proof of address from the list below dated within the last three months:

- Tenancy agreement
- Utility bill
- Bank statement
- Pay slip
- Home office paperwork

Your medical records may take up to 12 weeks to arrive from your previous GP surgery, therefore if you take regular medication please make an appointment with our Practice Pharmacist to ensure your medication continues to be prescribed to you.

You may also like to attend for a new patient health check appointment with one of our Health Care Assistants.

If you have internet access or a smart phone the practice offers an online booking service which gives you the facility to book appointments in advance, 24 hours a day, 7 days per week. This service also allows you to view and order your repeat prescription. Please see enclosed application form. ID is also required.

Yours sincerely

Thornfield Medical Group

Text message reminders service opt **out** (appointment & recalls) ☐
Email messages opt **out** (Practice newsletters & recalls) ☐

Title	Mr / Mrs / Miss / Ms / Dr / MX
Full name	
Date of Birth	
Contact phone number**(s)**	
Email address	

Please tell us about any health problems you have at the moment or which have affected you in the last year:

Please list any other illnesses or operations you have had in the past, and roughly when they were: • • • •

Do you attend any hospital clinics? (if so please specify)

Medication

Name & Dose	How often
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Do you take any kind of non-prescribed drugs? For example drugs bought from the chemist or supermarket, or any other drugs (if so please specify)

Do you have a preferred pharmacy? (if so please specify)

Smoking Status (circle as appropriate)

Do you smoke? Yes No

Have you ever smoked? Yes No

If yes, how many per day? ________________________

If you have smoked in the past, when did you stop? ________________________

Alcohol Status (Audit C)

	Points 1	Points 2	Points 3	Points 4	Points 5
How often do you drink alcohol?	Never	Monthly or less	2-4 times per month	2-3 times / week	4+ times / 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+ if female or 8+ if male, on a single occasion?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the last year have you been unable to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often in the past year have you failed to do what is normally expected because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the past 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 most days
How often during the past year have you left drink or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or most days
How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or most days
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

Total points _______

Are you allergic to anything? (circle as appropriate) Yes No If yes please specify _______________

Are you registered disabled? (circle as appropriate) Yes No

For Women

When was your last cervical smear? ______________________________

We offer all women a smear every three or five years - age and on previous results depending.

Have you ever had a Rubella (German Measles) Injection? Yes No Not sure

Family History

Some illnesses can run in families, so it is useful for us to know what health issues people in your family have had. (circle as appropriate)

Angina/heart attack over the age of 60: **Yes** **No**

Angina/heart attack under the age of 60: **Yes** **No**

Stroke over the age of 60: **Yes** **No**

Stroke under the age of 60: **Yes** **No**

Diabetes: **Yes** **No**

Asthma: **Yes** **No**

Other: _________________________

Ethnicity

What is your Ethnicity ____

Next of Kin

Name________________________________

Relationship to you ________________________________

Address ________________________________

____

Contact Number ________________________________

If your first language is not English, please specify ________________________________

Carer (please only complete if appropriate)

Do you look after someone who is unwell, frail, disabled or mentally ill? If so, you are classed as a carer. We are very interested in identifying carers, especially those who may be caring without help or support.

Name of the person who you look after ______________________________

Relationship to you ______________________________

Address (if different from yours) ______________________________

Telephone number ______________________________

GP surgery ______________________________

Please pass my details onto the Carers service **Yes** **No**

Please refer me to Adult Care services for a Carers Assessment **Yes** **No**

As a carer, your own health is very important. We offer health checks to carers with one of our Health Care Assistants. Why not make an appointment at reception?

Veterans (circle as appropriate)

Are you a Veteran? Yes **No**

Veterans are persons that have served in any branch of the armed forces or reserves for at least one day.

We offer health checks to Veterans with one of our Health Care Assistants. Why not make an appointment at reception?

Autism (circle as appropriate)

Are you on the Autistic spectrum? **Yes** **No**

Would you be interested in our 'health passport' to allow reasonable adjustments to be made when visiting the practice? **Yes** **No**

Summary Care Record

You can choose to have a Summary Care record. You do not need to do anything. This will happen automatically. If you don't want a summary care record please tick here ☐ and ask a receptionist for an 'opt out' form. If you require more information about what summary care record is please ask a receptionist.

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THORNFIELD MEDICAL GROUP POLICY ON PRESCRIBING OPIOPID PAINKILLERS SUCH AS GABAPENTIN, PREGABALIN AND CODEINE.

In line with National guidance, the practice does not support the prescribing of medication such as Morphine, Oxycodone, Fentanyl, Tramadol, Pregabalin, Gabapentin or Codeine for long-term use.

We agree with the National Institute of Clinical Excellence (NICE) that such drugs should only be used short term (less than 3 months) or in end of life care. There is no good clinical evidence to support their use otherwise and concerns regarding their serious side effects are very real.

Patients joining the surgery who take these medications will be given an appointment with a GP or our Practice Pharmacist to discuss the reduction and ultimately stopping of these drugs.

Practice Partners
Thornfield Medical Group.

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ONLINE AGGREEMENT

Name
DOB
Address

Phone number

The Practice will:

- Provide the user with a unique ID and password
- Patients 16 years or over to register
- Allow 24 hours access via the internet, to book/cancel a GP appointment after registration
- Carry out an audit of user usage to ensure proper use of the system
- Stop access should a user be shown to be abusing the system

The Patient will:

- Safeguard their unique ID and password
- Report any lost ID or password information immediately to the provider
- Cancel unwanted appointments online or by contacting the surgery direct
- No abuse on the messaging service and understand no medical/urgent messages to be sent

Signed by or on behalf of the Patient ______________________ Date_____________

Signed by or on behalf of the Practice ______________________ Date ____________

Admin check box

Carer/Veteran pack given if appropriate ☐
Online details given ☐

Staff signature _________________________