Bassingham Surgery

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Dear New Patient

WELCOME TO BASSINGHAM SURGERY

In your registration pack you will find

- A new patient registration form
- A new patient questionnaire, this helps us until we receive your medical records.
- A text messaging consent form, we use text messaging to confirm appointments have been booked and also to remind patients to attend their appointments
- A medication form

We can also provide you with a practice leaflet for your information. You can also find useful information on our website www.bassinghamsurgery.co.uk

You should be aware that until we have received your medical records and they have been reviewed we will not be able to complete any insurance paperwork or offer you advice with regard to travel vaccinations.

Please note that repeat prescriptions cannot be issued to new patients unless they have been seen by a GP or Nurse Prescriber. If you are currently taking regular medication please ensure you have a months' supply from your previous surgery prior to handing in this application. You will then need to make an appointment with a GP to ensure that your medication is added onto our clinical system in time for your next prescription to be issued.

Please complete the form relating to your medication.

Thank you for your co-operation in completing the attached documentation.

We trust you will be happy with the services we provide.

Yours sincerely

Juliet Brewer
Practice Manager

New patient registration

IMPORTANT

Once you have handed your forms in at Bassingham Surgery, please allow 3 working days for the registration to be processed, at which point you should be able to ring for an appointment should you need to.

Any patient over 18 can book in for a New Patient check, this is a 20 min appointment with a Health Care Assistant and includes taking a brief medical history and lifestyle questions. Please speak to Reception if you would like to book an appointment.

Please be aware if forms are filled in incorrectly or information is missing your registration may be delayed.

ID

As part of the registration process we need to see 2 forms of identification. Photo ID, such as a passport or driving licence AND proof of your address, eg utility bill, mortgage/rental agreement, bank statement

Admin Only

Name _____ Passport or licence number _____

Proof of address witnessed by _____ Staff name

Named accountable GP - PB MH HW Pt informed - YES NO

SHARING MEDICAL RECORDS

Please read each statement and mark Yes or No and sign below to confirm your preferences.

I consent to Bassingham Surgery sharing my medical record with other medical organisations that use the SystmOne computer system. **Yes No**

I consent to Bassingham Surgery receiving medical information from other medical organisations that use the SystmOne computer system. **Yes No**

Signed _____ Date _____

YOUR EMAIL ADDRESS _____

May we include your email address in our patient reference group database? This is for Bassingham Surgery only and will involve us occasionally contacting you by email with a short survey (no more than two a year)

YES NO Signed _____

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 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

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*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km 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

Signature confirming my consent to join the NHS Organ Donor Register Date _____/_____/_____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register Date _____/_____/_____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

052019_006 Product Code: GMS1

NHS Family doctor services registration

GMS1

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

Practice Stamp

Authorised Signature

Name

Date _____/_____/_____

SUPPLEMENTARY QUESTIONS 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 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
PRC validity period (a) From:	DD MM YYYY	(b) To: 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.

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.

WHO IS YOUR NEXT OF KIN? _____

How are they related?_____WHAT IS THEIR TELEPHONE NUMBER?_____

ARE YOU A CARER? YES NO
If yes who do you care for? _____

DO YOU SMOKE? YES NEVER SMOKED EX SMOKER

If yes, would you like advice to help to stop? **YES NO**

DO YOU DRINK ALCOHOL YES NO IF YES HOW MUCH PER WEEK? _____

HOW MUCH DO YOU WEIGH? _____ HOW TALL ARE YOU? _____

DO YOU OR YOUR FAMILY HAVE ANY HISTORY OF THE FOLLOWING?

HEART DISEASE	**YES NO**	DIABETES	**YES NO**
ASTHMA	**YES NO**	HYPERTENSION	**YES NO**

Please give further details

_____

_____

HAVE YOU EVER HAD

A FLU VACCINATION?	**YES NO**
A PNEUMONIA VACCINATION?	**YES NO**

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY?
IF SO PLEASE GIVE DETAILS eg. Operations, Serious Illness ie Hepatitis b, Hepatitis c, HIV or Aids or Allergies.

_____

_____

MEDICATION DETAILS

Please list below your current repeat medication

PLEASE NOTE THIS MEDICATION CANNOT BE ISSUED UNTIL YOU HAVE BEEN SEEN BY A CLINICIAN AT THIS SURGERY. PLEASE ENSURE YOU HAVE A MONTHS WORTH OF MEDICATION BEFORE SUBMITTING THIS FORM.

ELECTRONIC PRESCRIBING

If you live outside our Dispensing area (Witham St Hughs or Navenby) and would like to nominate a Pharmacy to have your prescriptions sent to electronically, please indicate below your preferred Pharmacy. **Please put full pharmacy name, address and post code.**

Admin Only

New patient appointment made? Yes / No

Date -
Time -
Clinician -

TEXT MESSAGING CONSENT

Please fill in your details and read the policy below carefully before signing

Name of patient	**Date of birth**
NHS number	
Mobile tel No	
Parent/guardian name if patient is under the age of 10. Please state relationship	

I would like to receive text messages to the above mobile telephone from Bassingham Surgery and understand that the content will only relate to the medical record belonging to myself/my child. It may include confirmation of an appointment, a reminder alert or short messages asking me to contact the Surgery.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing, quoting the above mobile number.

Text messages may be sent to a parent/guardian if the child is 16 years of age or under.

I will advise the practice if I change my mobile number and understand that a new consent form will be required.

I am aware that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed.

I confirm that I understand the details above and that I am the patient listed above. I understand that it is my responsibility to advise Bassingham Surgery of any changes to my mobile telephone number.

Signature _____ **Date** _____

Form must be signed by the named patient unless the patient is a child under the age of 16 years.

PLEASE INDICATE YOUR ETHNIC ORIGIN BELOW

WHITE	BRITISH/IRISH/OTHER _____
MIXED	WHITE AND BLACK CARIBBEAN/WHITE AND ASIAN/OTHER _____
ASIAN OR ASIAN BRITISH	INDIAN/PAKISTANI/BANGLADESHI/OTHER _____
BLACK OR BLACK BRITISH	CARIBBEAN/AFRICAN/WHITE AND ASIAN/OTHER _____
CHINESE OR OTHER ORIGIN	CHINESE/OTHER _____

FEMALE PATIENTS 25- 65 YEARS

WHEN WAS YOUR LAST CERVICAL SMEAR? _____

WHAT METHOD OF CONTRACEPTION DO YOU USE? _____