# The Riverside Practice, March, Cambridgeshire
# Patient Registration Pack

Pack Contents

1. Joining Instructions (this page)
2. NHS GMS1 application form
3. The practice New Patient Questionnaire
4. Summary Care Record – Information and Opt-Out Form
5. Sharing of Medical Record – Consent form

Thank you for joining our practice, we look forward to taking care of you. To join the practice please follow the steps described below to complete your registration.

**Please note that you will not be registered at the practice until you return all the documents to the practice. Please ensure you fill all forms in fully.**

| | |
|---|---|
| Step 1 | Read the Patient Information leaflet which you can find on our website. This will provide you with the essential information about the practice and how to access our services. |
| Step 2 | Complete the NHS GMS1 form to register your details with the practice. |
| Step 3 | Complete the New Patient Questionnaire. |
| Step 4 | Review information about the Summary Care Record and decide if you wish to opt out of this scheme. If you DO wish to opt out then you must complete the Summary Care Record Opt-Out form and return to us.<br><br>Information about the Summary Care Record can be found:<br>• In the application pack with the opt-out form.<br>• http://www.nhscarerecords.nhs.uk/summary/<br>• The practice website |
| Step 5 | Read the enclosed form "Your health record and sharing of information" and compete the form stating your choices. |
| Step 6 | Return ALL of the above back to the practice. This can only be done in person or by post. |
| Step 7 (Optional) | If you would like an online registration so you can book/cancel appointments and order repeat medication online you must attend the practice in person. This must be at least 1 week after you have returned the above application forms to allow us time to register you fully.<br><br>When you attend the practice to obtain your online access details you should bring with you some photo identification. This helps us to protect your confidentiality. |

# NHS Family doctor services registration GMS1

## Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

First names .....

Date of Birth

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 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

.....

Version 01/02

***Please see right re: Organ donation***

NHS GSM1

## NHS Organ Donation registration

I would like to join the NHS Organ Donation 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

## NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give 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 your 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

.....

☐ 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.

Authorise Signature

Name Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

**RIVERSIDE PRACTICE - NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

To register with the Practice please complete this questionnaire as fully as possible and provide evidence of ID (ie driving licence, passport, ID card etc)

**PART 1: ABOUT YOU.**

| | |
|---|---|
| Title: Mr Mrs Miss Ms Dr Other (please state) | |
| Surname: | Forename(s): |
| Date of birth: | Marital status: |
| Address: | |
| Post code: | |
| Home telephone: | Mobile telephone: |
| Work telephone: | |
| Occupation / Last occupation (if retired) | |
| Next of kin: | Their relationship to you: |
| Their telephone number: | Their mobile number: |
| Address of next of kin: | |

**A Carer is someone who provides care on a regular and unpaid basis for an elderly, ill or disabled relative or friend.**

| |
|---|
| Are you a carer? |
| If so, who do you care for |
| What is their relationship to you? |

| | | |
|---|---|---|
| Does somebody care for you? | | |
| If so, who cares for you? | | |
| What is their relationship to you? | | |
| What is their telephone number? | Daytime: | Mobile: |

**Text Messaging Appointment Reminder Service (only relevant for patients over 16)**
Please tick if you would you rather NOT receive text messages ☐

**Practice Emailing List**
The Practice and the Patient Participation Group would like to contact you via email on occasion to ask for your views about the service or send you useful information such as the Newslink newsletter from the Patients Association.
Please tick this box if you would rather **NOT** be contacted by email. ☐

Email address: If you would like to be contacted by emailed please enter the **Email address** below: (write VERY clearly please in BLOCK CAPITALS)

| |
|---|
| |

**Ethnicity**
This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. Please tick as appropriate.

White

| | |
|---|---|
| | British |
| | Irish |
| | Any other white background (please specify) |

Mixed

| | |
|---|---|
| | White and Black Caribbean |
| | White and Black African |
| | White and Asian |
| | Any other mixed background (please specify) |

Asian or Asian British

| | |
|---|---|
| | Indian |
| | Pakistani |
| | Bangladeshi |
| | Any other Asian background (please specify) |

Black or Black British

| | |
|---|---|
| | Caribbean |
| | African |
| | Any other black background (please specify) |

Chinese or other ethnic group

| | |
|---|---|
| | Chinese |
| | Any other |

| | |
|---|---|
| Country of birth: | First spoken language: |

**Thank you, now complete part 2….**

**PART 2: ABOUT YOUR HEALTH.** Please answer the following medical questions as fully as possible to help us help you.

| | |
|---|---|
| Your weight: | Height: |
| Do you smoke? Yes / No | Are you an ex-smoker? Yes / No |
| Would you like any advice and/or treatment regarding stopping smoking? Yes / No | |
| Are you on any Medication? Yes / No **(*If Yes please attach your latest repeat slip from your previous surgery.*)** | |

**Alcohol Questionnaire (please answer all 10 questions – over 18's only)**

| | |
|---|---|
| Q1. How often do you have a drink containing alcohol?<br>Never ☐<br>Monthly or less ☐<br>2 to 4 times a month ☐<br>2 to 3 times a week ☐<br>4 or more times a week more ☐ | Q2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?<br>1 or 2 ☐<br>3 or 4 ☐<br>5 or 6 ☐<br>7 to 9 ☐<br>10 or more ☐ |
| Q3. How often do you have 6 or more standard drinks on one occasion?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ | Q4. How often during the last year have you found that you were not able to stop drinking once you had started?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ |
| Q5. How often during the last year have you failed to do what was normally expected from you because of your drinking?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ | Q6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ |
| Q7. How often during the last year have you had a feeling of guilt or remorse after drinking?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ | Q8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?<br>Never ☐<br>Less than monthly ☐<br>Monthly ☐<br>Weekly ☐<br>Daily or almost daily ☐ |
| Q9. Have you or someone else been injured as a result of your drinking?<br>No ☐<br>Yes, but not in the last year ☐<br>Yes during the last year ☐ | Q10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?<br>No ☐<br>Yes, but not in the last year ☐<br>Yes during the last year ☐ |

**Family History**

| | |
|---|---|
| Heart Disease, heart attacks, angina (under 60) ☐ | Which family member? |
| Stroke (under 65) ☐ | Which family member? |
| Asthma ☐ | Which family member? |
| Diabetes ☐ | Which family member? |
| Hypertension (High blood pressure) ☐ | Which family member? |
| Raised Cholesterol ☐ | Which family member? |
| Cancer (please state type of cancer) ☐ | Which family member? |

**Allergies – are you allergic to any medications OR foods?**

| | | | |
|---|---|---|---|
| Penicillin | ☐ | Nut Allergy | ☐ |
| Aspirin | ☐ | Pollen | ☐ |
| Elastoplast | ☐ | Bee Stings | ☐ |
| Latex | ☐ | Wasp Stings | ☐ |
| Other (please specify) | | | |

**Medical History. Have you or do you suffer from any of the following?**

| | | | |
|---|---|---|---|
| Heart Disease | ☐ | Stroke | ☐ |
| Epilepsy | ☐ | COPD | ☐ |
| Diabetes | ☐ | Depression | ☐ |
| Asthma | ☐ | | |
| Other (please specify): | | | |

**Immunisations.** Please supply a record of all immunisations/vaccinations to date.

| |
|---|
| |

| | |
|---|---|
| Signature: | Date of form completion: |

***Data & Confidentiality Protection***

*The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 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.*

**Your emergency care summary**

Dear Patient

# Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice:

• **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

• **No I do not want a Summary Care Record** – attached is an opt-out form. **Please complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to the Patient Experience Team on **0800 2792535** or **CAPCCG.pet@nhs.net** , visit the **Cambridgeshire & Peterborough Clinical Commissioning Group website - www.cambridgeshireandpeterboroughccg.nhs.uk**, telephone the dedicated NHS Summary Care Record Information Line on **0300 123 3020**, or visit their website **www.nhscarerecords.nhs.uk**, or contact your GP practice staff.

Additional copies of the opt-out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on **0300 123 3020**.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Practice Manager

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

# OPT-OUT FORM

## Request for my clinical information to be withheld from the Summary Care Record

### If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS Number (if known) .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature .....

Relationship to patient ..... Date .....

### What does it mean if I **DO NOT** have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:
- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date .....

# **Your health record** and **sharing** of **information**

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Please read this leaflet carefully. It provides information about the choices you can make about sharing your health record. Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical details.

We use a secure electronic health records system called SystmOne. With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.

Many organisations may use SystmOne including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.

You have **two choices** which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.

**Please read this leaflet and fill in your choices.** You may wish to keep this section for future information. Please contact the Patient Experience Team on 0800 2792535 or CAPCCG.pet@nhs.net if you have any queries.

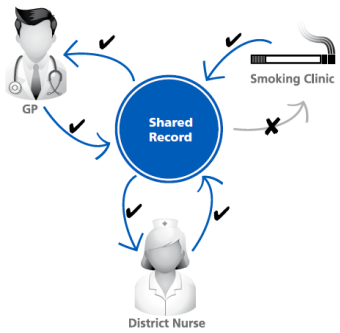
**Please note:** if you have previously opted out of sharing your information via the Summary Care Record, you will still need to complete this form with your choices about sharing your health record within SystmOne.

**For further details visit www.cambridgeshireandpeterboroughccg.nhs.uk**

**Your choices** at **each practice** or **service**

**Sharing OUT** - This controls whether your information recorded at this practice or service can be shared with other healthcare services.
**Sharing IN** - This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.

Imagine you're receiving care from three services: your GP, a district nurse and a smoking clinic. You want your GP and District 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 choices at each practice or service 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.

**You can change your choices at any time. Let each practice or service know.**

**Note:** You can request individual entries in your record to be marked as 'Private'. These are not shared with the rest of your record even if you choose to share out.

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**Please complete your details below and make your choices.** Please complete a separate form for each of your dependents. Complete this section and return to the practice or service receptionist.

PATIENT NAME: …… DATE OF BIRTH: ……

ADDRESS:……

PHONE: …… SIGNATURE: …… DATE: ……

**The choices you would like to make about sharing your health record:**

| | |
|---|---|
| **SHARING OUT** | **I would like my health record at this practice or service to be shared with other healthcare services providing care for me. YES / NO** |
| **SHARING IN** | **I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services. YES / NO** |

**My choices apply to my record here at …… PRACTICE or SERVICE**