StAMC

1. New Patient Registration (over age 15)

To enable us to register you as quickly as possible please complete a separate complete, registration form 1 **for each family member over age 15 applying.**

If you are applying for a child under the age of 15 please complete form 1.1 New Patient Registration (under age 15)

Please complete all parts of the registration process; by doing so you will help us to provide you with more efficient services.

A. New Patient - Family doctor services registration (GMS1)

Purpose: to obtain basic details about you.

B. New Patient - Health Questionnaire

Purpose: to help the doctor make an initial assessment of your health and assist your future treatment.

C. New Patient - Application for access to website online services

Purpose: to enable you to access a range of online services, e.g. request repeat prescriptions, book non-urgent appointments. You then don't need to queue at the practice or wait on the telephone, just go online at home, at work or any location with internet access.

D. Consents to additional SAMC services

1. Summary Care Record opt-out

Purpose: for you to decide whether or not you want to have your clinical information withheld from your Summary Care Record.

2. SAMC Information updates and Newsletters by email

Purpose: for you to decide whether or not to receive Information updates and Newsletters by email

3. Telephone messages from SAMC

Purpose: for you to decide whether or not you wish SAMC to leave a voicemail message on your phone in the event that we need to contact you.

E. Carers and Accessible information

Purpose: to gain information from you to allow the practice to support you as a patient at SAMC.

St. Andrew's Medical Centre, Pinewood Gardens, Southborough, Tunbridge Wells, Kent TN4 0LZ

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StAMC

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A. New Patient - Family doctor services registration

Purpose: to obtain basic details about you.

NHS **Family doctor services registration** GM51

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

Version 01/02

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor 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

NHSBlood 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:

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 CHSlist 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

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

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StAMC

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B. Patient Health Questionnaire

Purpose: to help the doctor make an initial assessment of your health and assist your future treatment.

Your doctor may invite you for an initial examination, discussion about your health, and general check.

MORE ABOUT YOU					
Surname			**First names**		
Age		**Weight**		**Height**	
Occupation					

ETHNIC GROUP (circle which applies)				
White British	**White Irish**	**White other**	**Mixed white&black Caribbean**	**Mixed white&black African**
White & Asian	**Pakistani**	**Indian**	**Other mixed background**	**Bangladeshi**
Other Asian	**Caribbean**	**African**	**Other black background**	**Chinese**
Other				

FAMILY HISTORY Is there any of the following in your family (father, mother, brother, sister) before age of 65? (circle which applies and if 'YES' enter details)			
Heart Disease (heart attacks, angina)?	Yes/No	**Which family member?**	
Diabetes?	Yes/No		
Stroke?	Yes/No		
High Blood pressure?	Yes/No		
Cancer?	Yes/No		
Cancer location?			

DIET (circle which applies)	
Do you add salt to your food after cooking?	Yes/No
Do you have a varied diet including milk/meat/vegetables/fruit?	Yes/No
Has your Cholesterol been checked in the last 2 years?	Yes/No

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StAMC

SMOKING (circle which applies and if 'YES' enter details if required)				
Do you smoke?	Yes/No	**How many cigarettes per day?**		
		How many cigars per day?		
		How many ounces of tobacco per day?		
Age started smoking				
Did you smoke?	Yes/No	**How much did you smoke per day?**		
Age you stopped				
Passive Smoking: are you exposed to smoke	**At work?**	Yes/No	**At home?**	Yes/No

EXERCISE (circle which applies)	
Do you take regular exercise?	Yes/No
If 'yes', what sort of exercise?	
If 'yes' how many times per week?	

PAST MEDICAL HISTORY	
Details of any hospital treatment as an in-patient	
Details of any treatment for any chronic medical conditions	
Dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound	

IMMUNISATIONS	
Dates of Triple/polio/HIB	
Dates of MMR	
Date of last Tetanus	

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MEDICATION Give details of any medication which you take (prescribed or otherwise)	
Name of drug	**Dosage**

ALLERGIES (circle which applies and if 'YES' enter details)	
Are you allergic to any substances or foods?	Yes/No
Details	

FEMALE PATIENTS	
Date of most recent cervical smear	
Result of most recent smear	
Give details of any complications in pregnancy	

CARERS (circle which applies)	
Do you need / have anyone who looks after you, or your daily needs, as a Carer?	Yes/No
If 'Yes' please complete form **E. Carers and Accessible Information form at page 11**	
Do you care for anyone else? If 'Yes' ask Reception about Carers' support	Yes/No

ACCESSIBILITY – INFORMATION & LANGUAGE (circle which applies)	
Do you need a language interpreter?	Yes/No
If 'Yes' please state your first choice of language	
Do you need information in a certain format?	Yes/No
If 'Yes' please complete form **E. Carers and Accessible Information form at page 11**	

ADVANCE DECISIONS (Living Will) or **POWER OF ATTORNEY** (circle which applies)	
Do you have a power of attorney in place or advanced decision to refuse treatment?	Yes/No
If 'Yes' please supply a copy that may be added to your medical record – more details about advance decisions are available from Age UK	

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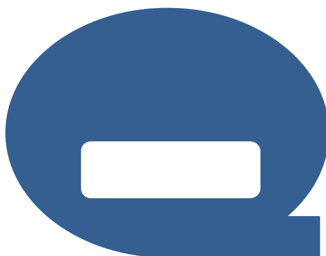
ALCOHOL QUESTIONNAIRE (patients over 16)

This is one unit of alcohol:

…and each of these is more than one unit

Questions	**Scoring system** 0	1	2	3	4	**Your score**
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 been unable to remember what happened the night before because you had been drinking?	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	
In 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		On one occasion		On more than one occasion	



Would you like further advice on drinking? (circle)	Yes/No

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StAMC

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C. Online Services Application

Purpose: to enable you to access a range of online services, e.g. request repeat prescriptions, book non-urgent appointments. You then don't need to queue at the practice or wait on the telephone, just go online at home, at work or any location with internet access.

PATIENT DETAILS (complete in BLOCK CAPITALS)			
Surname		**First name**	
Address		**Date of birth** (dd/mm/yy)	
		Home telephone	
Postcode		**Mobile number**	
Email address			
YOUR AUTHORISATION (must complete all marked*)			
***Signature**		***Date** (dd/mm/yy)	
*I agree to the terms & conditions below (tick here)			
if applying for someone else please enter relationship to patient			

Terms and conditions (by signing I confirm that):

- I will be responsible for the security of my username and passwords and the information that I see or download
- If I choose to share my information with anyone else this is at my own risk
- I will contact SAMC as soon as possible if I suspect that my account has been accessed by someone without my agreement
- If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact SAMC as soon as possible
- I agree to use the system in a responsible manner
- I agree that my details may be used to contact me with information about my online account and the online services I use.
- I agree that I cannot use this service as a means of communication with SAMC for other purposes and will not use it for urgent matters

SAMC use only			
Patient NHS number			
Computer ID number		Date on system:	Date ID to patient:
ID verified by	Date:	Authorised by:	Date:
ID presented (circle)	Passport/Driving licence/ Bus pass/ other state:		

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D. Consents to additional services - guide

D1. Summary Care Record opt-out

Purpose: *for you to decide whether or not you want to have your clinical information withheld from your Summary Care Record.*

You are entitled to request that your clinical information be withheld from the Summary Care Record and you should complete this form if you wish to do so.

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:

- Phone the Summary Care Record Information Line on 0300 123 3020
- Contact your local Patient Advice Liaison Service (PALS) or
- Speak with Reception

D2. SAMC Information updates and Newsletters by email

Purpose: *for you to decide whether or not to receive Information updates and Newsletters from SAMC by email (these will only ever come from the medical centre and not from any third party).*

D3. Telephone messages from SAMC

Purpose: *for you to decide whether or not you wish SAMC to leave a voicemail message on your phone in the event that we need to contact you.*

In accordance with the Data Protection Act 1998 we require written consent from any patient who is happy for us to leave a message on their answer phone in the event that we need to contact them. If we do not have written consent, we are unable to leave any message on any answer phone or with a third party.

The message left will not contain any medical information: *St. Andrew's medical centre called at [time/date] and please could [patient's name] call 01892 515455 and speak to [department]*

Please complete the form on the next page

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D. Consents to additional services - form

CONSENTS			
Patient surname		**First name**	
D.O.B (dd/mm/yy)		**Email**	

D1	**Summary Care Record (SAR) Opt-Out** **Put an X** in the box on the right if you **DO NOT want** clinical information to be seen by the hospitals. (We recommend leaving blank as a Summary Care Record allows hospitals to see your current medication and allergies.)	
D2	**SAMC Information updates and Newsletters by email Opt-Out** **Put an X** in the box on the right if you **DO NOT WANT** to receive Information updates and Newsletters by email	
D3	**Telephone messages from SAMC Opt-Out** **Put a** √ in the box on the right if you **<u>DO</u> WANT** to receive voicemail messages from SAMC	

Home tel. number		**mobile tel. number**	

Put a √ in the box on the right if you **<u>DO</u> WANT** to give consent for SAMC to leave a message about any aspect of my medical treatment with a **THIRD PARTY.** (Any message left will not contain any medical information.

name of THIRD PARTY			
their home tel. number		**their mobile number**	
Signature		**Date**	

These consents will remain in force until we receive a notice of cancellation.

<u>Please ensure that you inform us of any change in any of your contact details.</u>

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E. Carers and Accessible Information form

ACCESSIBLE AND CARERS INFORMATION FORM		
Best for the practice to contact you (circle those that apply) (please note not all information can be sent electronically)	**standard letters?**	Yes/No
	email?	Yes/No
	telephone?	Yes/No
	or contacting your carer?	Yes/No
Prefer letters in larger font than standard 12pt? (if 'Yes' circle preferred font size)	**font Sizes:** 22pt -24pt - 28pt	

Carers details		
	Carer 1	**Carer 2**
Role (circle which applies)	**Paid professional** Yes/No **Main carer** Yes/No	**Paid professional** Yes/No **Main carer** Yes/No
Carer's name		
Carers full Address		
Carer's telephone		
Relationship to you		
Are you happy for SAMC to share your medical information with your carer?	Yes/No	Yes/No

Accessible - If you need help when you see us – who from? (circle answer)	
Carer/Support worker/family member	Yes/No
British Sign Language (BSL) Interpreter	Yes/No
Other support (enter details)	

Accessible - how can *we* help when we see you? (circle answer)	
Do you need longer appointment?	Yes/No
Do you need a visual alert when called into the consulting room?	Yes/No
Do you use a hearing aid?	Yes/No
Do you use a personal communication tool? (if 'Yes' state which type)	
Are you happy for us to share your communications needs with other health professionals involved in your care?	Yes/No

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