RALEIGH SURGERY

33 Pines Road
Exmouth
EX8 5NH
Tel: 01395 222499 Fax: 01395 225493

Welcome to Raleigh Surgery

We are pleased to welcome you to Raleigh Surgery. To enable us to register you with a doctor, please complete the attached registration form and questionnaire and return them to a member of the reception team.

Please fill in as much information as possible on the questionnaire, as the reception team may need to offer you an appointment with a doctor or nurse for a medical review. If this is necessary, they will book an appointment for you.

We hope you will be happy with the care we provide, and find our practice helpful and friendly at all times.

Best wishes.

Yours sincerely,

Mrs Louise Ford
Practice Manager

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*

**Not all doctors are authorised to dispense medicines*

☐ 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

☐ **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**

NHS 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

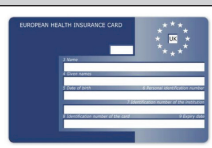
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:
	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.

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Patient Health Questionnaire for Adults

Thank you for registering with our practice. To enable us to give you the best possible care while we await delivery of your medical records from your previous Doctor, please could you spare a moment to complete this brief form and hand it back to the Receptionist.

Identification for registration: Please bring a recognised form of ID for registration when you register

Title …… Surname …… First Name ……
Occupation …… Email ……

Please note: as a reminder, we might send a text message to your mobile if you have an appointment with the doctor. If you do not wish to receive this service, please let us know.

Next of Kin (Relationship eg. Father, sister, etc.)……
Title …… Surname …… First Name ……
Home Address Phone Number ……..
……
……
……

Do you suffer from any of the following conditions? (Please tick where appropriate)

Coronary Heart Disease		Diabetes		Epilepsy		Asthma	
COPD		Stroke		Mental Health		Hypertension	
Cancer		Glaucoma					

About you

What is your first language? ……..

What is your ethnic group? ……

Have you ever been in the Armed Forces? ……..

Are you registered disabled? If yes, please give details: Yes / No

……

……

Carers

Do you have a carer? If yes, please give details: Yes / No

……

……

Are you a carer? If yes, please give details: Yes / No

……

Smoking (please tick which best describes you)

Never smoked ☐ Smoker ☐ Ex Smoker ☐

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week? ……

Would you like advice on giving up smoking? Yes / No

Alcohol Consumption (1 pint of beer = 3 units / 1 glass of wine = 2.5 units)

How many units of alcohol do you drink per week? ……

Height and Weight

What is your height? …… What is your weight? …….

Medication and Allergies

Please attach a copy of your current repeat medication slip or list any medicines being taken and the amount:

……

……

……

……

Do you have any allergies? If yes, please give details: Yes / No

……

……

Which Chemist would you like us to send your prescriptions to? (Circle as appropriate)

Pines	Withycombe	Lloyds Budleigh
Boots	Clarepharm	Jhoots
Lewis	Rowlands	Tesco

Other……..

Family Medical History

Please indicate close family members with these conditions:

Condition	**Please state family member with this condition**
Angina (below age 60)	
Angina (above age 80	
Heart Attack (below age 50 – men)	
Heart Attack (below age 60 – women)	
Heart Attack (above age 60)	
Cancer of the Bowel	
Cancer of the Breast	
Diabetes	
Glaucoma	
Hypercholesterolaemia (high blood fat)	
Hypertension	
Stroke	

Accessible information standard – if you require information in a different format or communication support, please indicate by circling your preferred format below:

Telephone	British Sign Language
Letter	In Makaton
Email	Grade 1 Braille
Text Message	Grade 2 Braille
Contact via Carer	In large font
Loud verbal communication	Telephone interpreter

Signature ……

Contacting you

I agree that I may be contacted from time to time, via email, and / or SMS with practice news, advice about my health and / or appointments.

Signature ……..
Date……

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Accessible information standard – if you require information in a different format or communication support, please indicate by circling your preferred format below:

Telephone	**British Sign Language**
Letter	**In Makaton**
Email	**Grade 1 Braille**
Text Message	**Grade 2 Braille**
Contact via Carer	**In large font**
Loud verbal communication	**Telephone interpreter**

Signature …….. Date ……

Contacting you

I agree that I may be contacted from time to time, via email, and / or SMS with practice news, advice about my health and / or appointments.

Signature ……..

Date ……

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Online Services

We have introduced a new online service for our patients. This is accessed via our website www.raleighsurgery.co.uk – by clicking on the online services link.

Here you have the ability to book appointments, order repeat medications and submit questions to the practice.
You need to register for this service in person at the practice.

Patient consent form

Please place a cross (X) in the boxes if you want to **OPT OUT** of the below schemes:

Patient Name ……

Patient Signature……

Date of Birth ……..

Summary Care Record – this is a summary of your **medication, allergies and adverse reactions** and can only be accessed by a **clinician in England** with your expressed consent. This will help with your care – http://systems.hscic.gov.uk/scr/patients	
Local Health Record – this allows access to your **FULL** health record to **out of hours service clinicians in Devon only** and with your express consent at point of care. This will help with your care	
Care.Data – the care.data programme will bring together securely health and social care information from different settings in order to see what is working really well in the NHS and what can be done better. This is not accessible to clinicians and **WILL NOT** help with your care; it is for statistical purposes only.	
Raleigh Surgery can view data that is recorded at other care services such as accident and emergency and the minor injuries unit.	