NHS Family doctor services registration GMS1

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:

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

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

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_____/_____/_____

082015_002 Product Code: **GMS1**

Please see overleaf re: Organ donation

NEW PATIENT QUESTIONNAIRE

for children and young adults under 16 years of age

Welcome to Amersham Health Centre. It often takes several weeks for your records to reach us from your previous doctor. Answering these questions will help us during this time. The information will be handled confidentially but if you are concerned about any of the questions leave them blank. After completion the questionnaire should be returned to the receptionist.

TODAY'S DATE .....

HAVE YOU EVER SEEN A DOCTOR AT THIS PRACTICE IN THE PAST YES / NO

Name:			**MALE / FEMALE** **Please circle**
Address:			
Date of Birth		**Place of Birth**	
Postcode			
Name and Contact Number of Parent/Guardian:			
Name (Parent/Guardian)			
Home Telephone Number			
Mobile Telephone Number			
*Please tick the box if you **don't** want to receive future text reminders*			
Please note once a child reaches the age of 15 they must give us their own mobile number for confidentiality reasons.			

Name & Address of School	
Details of Hospital Admissions and Operations and dates	
Other Illnesses	
Daily Medication	
Allergies (medicines, food, bites)	
FOR CHILDREN UNDER FIVE YEARS OF AGE **If your child is under 5 years old, please provide the name and address of his/her former Health Visitor at your last doctor's surgery**	

IMMUNISATION RECORD

To enable us to register your child we must have the dates of the following vaccinations. These may be obtained from your child's **patient-held record book** or by contacting your previous Health Visitor/ doctor's surgery. Unfortunately it is not enough to write 'up to date' as this is not accepted by the Child Health Department.

PLEASE SUPPLY DATES VACCINATIONS GIVEN	2months	3months	4months	12months to 13months	Pre-School Booster	Girls 12-13 years	Around 14years *new 2013 schedule*
Diphtheria, Tetanus, Pertussis, Polio and Hib DTaP/IPV/Hib							
Meningococcal B							
Pneumococcal disease PCV							
Rotavirus Rotavirus (Rotarix) (From July 2013)							
Meningococcal group C disease Men C							
Hib/MenC							

Measles, Mumps & Rubella MMR							
Diphtheria, Tetanus, Pertussis and Polio DTaP/IPV							
Cervical Cancer caused by Human Papillomavirus HPV (Gardasil)							
Tetanus, Diphtheria and Polio Td/IPV							

AGED 14 AND OVER - SMOKING

Do you smoke now?	**YES / NO or PASSIVE (somebody in the household smokes)**
If YES, how many cigarettes per day?	**Per day**
We strongly advise all smokers to stop smoking. We run a Smoking Cessation Clinic - please ask at reception if you require more information.	

Thank you very much for your help

The Surgery
Amersham Health Centre
Chiltern Avenue, Amersham, Bucks HP6 5AY

CONFIDENTIALITY OF HEALTH RECORDS

(As per the Caldicott Committee Report on review of Patient Identifiable Information, published in December 1997)

We ask you for information so that you can receive proper treatment. We keep this information, together with details of your care, because it may be needed if we see you again.

Sometimes the law requires us to pass on information, for example, to notify a birth. The NHS Central Register for England & Wales contains basic personal details of all patients registered with a General Practitioner. The Register does not contain clinical information. You have a right of access to your health records.

EVERYONE WORKING FOR THE NHS HAS A LEGAL DUTY TO KEEP INFORMATION ABOUT YOU CONFIDENTIAL.

You may be receiving care from other people as well as the NHS, so that we can work together for your benefit we may need to share some information about you. We only ever use or pass information about you if people have genuine need for it in both your and everyone's interests.

Whenever we can, we shall remove details, which identify you as an individual. Anyone who receives information from us is also under legal duty to keep it confidential. We ensure that we have your written consent when passing medical information to non-medical persons, e.g. solicitor, insurance companies etc.

THE MAIN REASONS FOR WHICH YOUR INFORMATION MAY BE NEEDED ARE:

- Giving you health care and treatment.
- Looking after the health of the general public.
- Managing and planning the NHS, for example:
    - Making sure that our services can meet patient needs in the future
    - Auditing clinical records
    - Preparing statistics on NHS performance and activity
    - Investigating complaints or legal claims
- Helping staff to review the care they provide to make sure it's of the highest standard.
- Training and educating staff (but you can choose whether or not to be involved personally).
- Research approved by the local Research Ethics Committee. (If anything to do with the research would involve you personally, you will be contacted to see if you are willing to be involved first).

Please indicate below whether you are willing for your records to be reviewed by an Authorised person, as appropriate.

I am willing*/not willing* for my records to be reviewed by an Authorised person. I understand that no information will be divulged to anyone else.

Name (please use capitals):	
Date of Birth:	
Parent / Guardian's Name	
Signed:	
Date:	

(* Delete as appropriate)

AMERSHAM HEALTH CENTRE

Summary Care Record – your emergency care summary – IMPORTANT!!

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, healthcare staff treating you will have immediate access to important information about your health.

For more information visit the website **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

If you choose not to have a Summary Care Record, you can let us know at any time if you change your mind. We are supporting Summary Care Records and as a patient you have a choice:

Yes I would like a Summary Care Record - please tick this box and a Summary Care Record will be created for you.	
No I do not want a Summary Care Record – please tick this box if you do not want a Summary Care Record.	
Your Name	
Your Signature	
Date	
If you are filling out this form on behalf of a child, please give the additional details requested below:	
Child's name	
Your Signature	
Your Name	
Relationship to patient	
Date	

My Care Record – your local emergency care summary

My Care Record is similar to the Summary Care Record but the My Care Record will only be available to authorised health and social care staff locally, and they will ask your permission before they look at it.

We are supporting Summary Care Records and as a patient you have a choice:

Yes I would like a My Care Record - please tick this box .	
No I do not want a My Care Record – please tick this box if you do not want a My Care Record.	
Your Name	
Your Signature	
Date	

To which of these ethnic groups do you feel you belong:
Please tick the box that applies to you.

WHITE		**ASIAN OR BRITISH ASIAN**		**MIXED**	
British		Indian/British Indian		White and Black Caribbean	
Any other white background – please specify:		Pakistani/British Pakistani		White and Black African	
BLACK OR BLACK BRITISH		Bangladeshi/ British Bangladeshi		White and Asian	
Black Caribbean/ British Caribbean		Any other Asian background – please specify:		Any other mixed background – please specify	
Black African/ British African		**OTHER ETHNIC GROUPS**			
Any other black background – please specify:		Chinese			
		Other – please specify			
I do not wish to answer		Please state your first language:			

The Surgery
Amersham Health Centre

Patient Services – Patient Disclaimer / Information Sheet

This policy is intended to provide you (the patient) with all the information you need to know about Patient Services. It covers how your information is stored, how it is accessed, and patient confidentiality.

Patient Services is provided to you by our clinical provider INPS. This is a free service, funded by the NHS, to give patients online access to booking appointments and ordering repeat prescriptions.
Information Security:-

All information you provide to us is stored on our clinical providers secure servers. During registration, you will be asked to set up your own password to access this service. It is your responsibility to keep this password safe and confidential. Only you can access your own account unless you have registered children aged 14 and below.

The internet is not a secure place; however, our clinical provider INPS have gone to great steps in making sure your information is secure as possible. See privacy policy here www.patient-services.co.uk

Registering to use VOS:-
If you are aged 15 and over, you may register to use our Patient Services. You can only register yourself and must show at least one proof of identity, i.e. passport, driver's license or utility bill (if you are aged 15 to 18, we will also accept a young person's bus pass or library card). You must have an email address to register for Patient Services otherwise you can NOT use this service.

Registering someone else 15 and above:-
Unfortunately, you can NOT register another person who is 15 and above to use Patient Services. Each patient wishing to register to use Patient Services will need to show their own ID and supply their own email address. Exceptions are given where a patient is housebound and unable to visit the practice.

Registering Children 14 and below:-
Parents or legal guardians may register children aged 14 and below. Again, you will have to show proof of identity – your own, not your child's.

Access to children's / young adults account(s) when they turn 15 and above:-
Once a child, whose Patient Services account you have previously had access to, turns 15, access to their account by you or anyone else is prohibited. Please ask the child / young adult to visit the practice and register their own account to use Patient Services. Please note that they will need to bring in proof of identity, as specified above, and supply their own email address.

Missing 4 or more appointments within 12 months:-
If you have missed 4 or more appointments within 12 months which were booked but not cancelled, your Patient Services s account will automatically be disabled and you will not be able to access it. You can request to be set back up if you have not missed any subsequent appointments from the date your account was disabled. If you continue to miss appointments, we may disable your Patient Services account indefinitely.

I hereby agree to and understand the above information and consent to registering myself and / or my child aged 14 and below to use Patient Services. I understand that if I have registered a child aged 14 and below that when they turn 15, myself and anyone else, is prohibited to use their account and I must inform the child, if they wish to use this service, that they must visit the practice and register their own account as stated above. I also understand that missing 4 or more appointments which haven't been cancelled will mean my Patient Services account will be disabled for 6 months pending a review.

Print Name: _____ Signed: _____ Date: _____

AMERSHAM HEALTH CENTRE PATIENT SERVICES

We now offer our patients additional services which you may want to sign up for if you haven't done so already. Please fill in the forms below and hand back to reception.

- First Name: _____
- Last Name: _____
- Date of Birth: _____

You can now book your appointment and order your repeat prescriptions online from your computer using our new Patient Services.

Proof of identification required. Please complete this form, hand it back to reception and provide us with one of the following proofs of ID: passport, drivers licence or utility bill.

I would like to sign up to Patient Services

E-mail Address - PLEASE PRINT

_____

For office use: Proof of Identity seen: Passport ☐ *Driving Licence* ☐ *Utility bill* ☐ *Initials:* _____

Electronic Prescription Service

We can send completed prescriptions electronically direct to the pharmacy of your choice. All your prescriptions will be required to go to this pharmacy. If you would also like to use this service, please speak to your pharmacist. Alternatively, nominate the pharmacy of your choice below and ask for a copy of the letter 'A new way to get your medicines.' For more detailed information visit www.hscic.gov.uk/epspatients
Name and address of nominated pharmacy:

_____

_____

For office use: copy of letter 'A new way to get your medicines' given to patient ☐