

# Rectory Meadow Surgery

## REGISTRATION BOOKLET



Please complete all sections of this booklet in BLOCK CAPITALS then return it to reception with the following **TWO** documents to confirm your details, originals please (if you are also able to bring a set of copies it will save you time)

- 1) **Passport or birth certificate AND**
- 2) **Driving licence or a recent utility bill which gives your current address**

**PLEASE NOTE:** If you previously had a Summary Care Record, it may be unavailable whilst we transfer your records. If you would like help to complete the form please ask at reception.

**FORM GMS1**

**OUT OF AREA REGISTRATION**

**Patient's details**

Mr     Mrs     Miss     Ms    Surname .....  
 Date of birth \_\_\_ / \_\_\_ / \_\_\_\_\_    First names .....  
 NHS no \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Previous surname/s .....  
 Male     Female    Town & country of birth .....  
 Home address .....  
 .....

Postcode..... Telephone number .....

Mobile Telephone No.. ..... (By providing us with your mobile number, you consent to the Practice contacting you by mobile telephone which may include texting reminders of appointments.)

Please tick if you are:     Currently in the Armed Forces     A Military Veteran  
 The Dependant of a serving member of the Armed Forces

**Please help us trace your previous medical records by providing the following information :**

Your previous address in UK	Name of previous doctor/surgery whilst at that address
.....	.....
.....	.....

**If you have come from abroad and have been registered with the NHS in the past :**

Your previous address in UK	Name of previous doctor/surgery whilst at that address
.....	.....
.....	.....

Date you re-entered the UK ..... Date you left the UK .....

**If you have come from abroad and have never been registered with the NHS in the past**

Date you entered the UK .....

**If you are registering with the NHS having recently left the Armed Forces :**

Date of Enlisting \_\_\_/\_\_\_/\_\_\_    Date of Leaving \_\_\_/\_\_\_/\_\_\_    **Please supply a copy of your Discharge papers**  
 Address **before** enlisting .....  
 Name of previous doctor/surgery whilst at that address .....

**Signature of Patient** .....

**Please print name if signed on behalf of the Patient** .....    **Date** \_\_\_/\_\_\_/\_\_\_

**For Office use only: Patient has been informed of their named GP Yes / No**

**MEDICAL HISTORY**

Once you have registered there is usually a short delay before we receive your medical records. During this time it is helpful for us to have some basic information about your medical history and that of your immediate family so that we can provide you with the best possible care. Please answer the questions that follow as well as you can.

Have you or any of your relatives ever suffered from any of the following medical conditions?  
If so, please give details of the relationship and the date of onset.

	Your History		Family History	
	Tick	Age at onset	Relationship	Age at onset
Heart Disease				
Stroke				
High Blood Pressure				
Diabetes				
Asthma or other Respiratory Disease				
Allergies such as Hay Fever/Eczema etc				
Cancer				
Epilepsy				
Mental Illness				
Hypothyroidism				
Liver Disease				
Kidney Disease				

**FAMILY HISTORY**

If your parent(s), brother or sister have died as a result of illness, please let us know:

<u>Relationship</u>	<u>Age Died</u>	<u>Cause of Death</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....

**YOUR HISTORY**

Please list any other serious or chronic illnesses, major operations or disabilities (eg if you are blind, deaf or use a wheelchair):

<u>Year of onset</u>	<u>Problem</u>
.....	.....
.....	.....
.....	.....
.....	.....

**CARER INFORMATION**

**Do you care for someone who, as a result of a physical/mental illness cannot look after themselves?** Yes / No

If yes, for whom do you care? Name: ..... Relationship: .....

Are you their main carer? Yes / No

Please ask Reception for information about Carers Bucks

**DRUGS & MEDICINES**

**If you are taking regular medication please make an appointment with your new GP as soon as possible**

Please give details of any medication you are currently taking :

<u>Name of Medicine</u>	<u>Dose</u>	<u>How often taken?</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**ELECTRONIC PRESCRIPTIONS**

We can send your prescriptions direct to a pharmacy of your choice without the need for a paper prescription. See separate leaflet here at the Surgery or at local Pharmacies for more information

If you would like to take advantage of this service, please nominate your pharmacy here \_\_\_\_\_

**PLEASE NOTE:** *If you are from outside the area and had nominated a pharmacy local to your previous surgery we will remove this nomination and you will need to update it using the space provided above.*

**ALLERGIES & ADVERSE REACTIONS**

If any drugs or medicines have upset you in any way, please give details below:

<u>Name of Medicine</u>	<u>Date</u>	<u>Reaction</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....

**CHILD IMMUNISATIONS (Please complete this section if registering a child under 5)**

Please indicate which of the following immunisations the child has been given:

**Baby immunisations**

Diphtheria/Tetanus/Pertussis/Polio/Hib (5 in 1) + Pneumo	1 <sup>st</sup> visit	Date .....
5 in 1 + Men C	2 <sup>nd</sup> visit	Date .....
5 in 1 + Pneumo + Men C	3 <sup>rd</sup> visit	Date .....
Other(s) .....		Date(s) .....

**1-year immunisations**

MMR (Measles/Mumps/Rubella)	Date(s) .....
Hib/Men C	Date(s) .....
Pneumococcal	Date(s) .....
Other(s) .....	

**Pre-School Booster**

Dip/Tet/Pertussis/Polio (4 in 1)	Date(s) .....
2 <sup>nd</sup> MMR	Date(s) .....
	Date(s) .....

Please help us to assess the needs of our patient population and address any inequalities in access and health outcomes by providing us with the following information:

**DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS?**

For example sign language, lip reading, easy read or large print documents.  
If YES, please let us know how you would like the Practice to communicate with you.

**ETHNICITY**

To which of these ethnic groups do you feel you belong? (please tick) *Ethnic groups defined by the Department of Health*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> White British                 | <input type="checkbox"/> Mixed White & Asian | <input type="checkbox"/> Bangladeshi / British |
| <input type="checkbox"/> Irish                         | <input type="checkbox"/> Other Mixed         | <input type="checkbox"/> Other Asian           |
| <input type="checkbox"/> Other White                   | <input type="checkbox"/> Chinese             | <input type="checkbox"/> Caribbean             |
| <input type="checkbox"/> Mixed White & Black Caribbean | <input type="checkbox"/> Indian / British    | <input type="checkbox"/> African               |
| <input type="checkbox"/> Mixed White & Black African   | <input type="checkbox"/> Pakistani / British | <input type="checkbox"/> Other Black           |

Other (please specify) .....

If English is **not** your main spoken language please let us know what is \_\_\_\_\_

Do you need an interpreter?  Yes  No

**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

- Kidneys  Heart  Liver  Corneas  Lungs  Pancreas  All organs and tissue

**Signature confirming consent to inclusion on the NHS Organ Donor Register**    **Date** \_\_\_ / \_\_\_ / \_\_\_\_\_

.....  
For more information, please ask at Reception for an information leaflet, or visit the website [www.uktransplant.org.uk](http://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 home address provided eg/your place of work)

..... Postcode .....

**NEXT OF KIN / EMERGENCY CONTACT**

We will record this information and may use it if we are unable to reach you in an emergency or need to make urgent contact with somebody on your behalf.

Name	Contact number	Relationship	Please indicate whether :	Can discuss your record?
			Next of Kin / Emergency Contact	Yes / No
			Next of Kin / Emergency Contact	Yes / No
			Next of Kin / Emergency Contact	Yes / No

**LIFESTYLE INFORMATION**

**Smoking:** Do you currently smoke? (Please tick)

- Yes       No, I have never smoked       No, I used to smoke but don't smoke now

If you smoke, how much do you smoke? .....

If you smoke, have you ever been given smoking cessation advice by your doctor, or been referred to a specialist smoking cessation advice clinic?      Yes / No      Date .....

**Alcohol:** How many units of alcohol do you drink per week? .....Units (see guide below)

<b>1 unit</b>	<b>1.5 units</b>	<b>2 units</b>	<b>3 units</b>	<b>9 units</b>	<b>30 units</b>
½ pt of normal beer	Small glass of wine	½ pt of strong beer	Large bottle/ can strong beer	Bottle of wine	Bottle of spirits
Single shot of spirit	Bottle of Alcopops	Large bottle/can of normal beer	Large glass of wine		

**FAST ALCOHOL SCREENING TEST (FAST)**

For the following questions please tick the answer which best applies to you.

**1 drink = 1 unit (see table above)**

1. MEN: How often do you have EIGHT or more drinks on one occasion?  
WOMEN: How often do you have SIX or more drinks on one occasion?

- Never     Less than monthly     Monthly     Weekly     Daily or almost daily

2. 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

3. How often during the last year have you failed to do what was normally expected of you because of your drinking?

- Never     Less than monthly     Monthly     Weekly     Daily or almost daily

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

- No     Yes, on one occasion     Yes, on more than one occasion

**Rectory Meadow Surgery Patient Newsletter**

**Learn about new services, staff changes, health promotion and news from our Patient Group**



Tick here to receive a copy of our quarterly newsletter via email & to receive communications from our Patient Group

My Email address is \_\_\_\_\_



# Book Appointments and View your Medical Record Online

If you wish, you can register with Patient Access and use the internet to book your appointments and look at some aspects of your medical record online.

Appointments can also be made in person or by phone.

**Registration is personal but parents can register on behalf of children under 14yrs of age**

**Once registered with Patient Access you will be able to:**

 **view and cancel your existing appointments**

 **book one of the appointments available online (available up to 4 weeks ahead)**

 **view some aspects of your medical record, including Test results**

Being able to see your record online might help you to manage your medical conditions. It also means that you can access it from anywhere in the world should you require medical treatment. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

***If you would like to register, please read the Terms of Use and follow the steps below***

## Application for online services

### TERMS OF USE :

1) I have read and understood the information above provided by the practice
2) I will be responsible for the security of the information that I see or download
3) If I choose to share my information with anyone else, this is at my own risk
4) I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
5) If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

***Please tear off the section below and keep it to remind you how to complete your registration***

***- please allow at least 3 days from when you return this booklet***



- 
1. Please come to Reception **in person** with your passport or photo driving licence
  2. You will be required to confirm your acceptance of the 5 terms of use detailed above
  3. We will issue a registration letter with codes that are just for you
  4. When you get home, go to the Rectory Meadow Surgery website – [www.rectorymeadowsurgery.co.uk](http://www.rectorymeadowsurgery.co.uk) and click on the 'Book an Appointment' tab
  5. Click on 'Register' and, using the information in your letter, you can now complete your registration
  6. You will need to think of password which is unique to you. This will ensure that only you are able to access your record and make your appointments online – unless you choose to share your details with a family member or carer.



Your emergency care summary

## Summary Care Record – your emergency care summary

The NHS in England is using a national electronic record called the Summary Care Record (SCR) to support patient care. The Summary Care Record is a copy of key information from your GP record. It provides authorised healthcare staff with faster, secure access to essential information about you when you need unplanned care or when your GP practice is closed. Summary Care Records are there to improve the safety and quality of your 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. An SCR with additional information can also include reason for medication, vaccinations, significant diagnoses/problems, significant procedures, anticipatory care information and end of life care information. Specific sensitive information such as any fertility treatments, sexually transmitted infections, pregnancy terminations or gender reassignment will **not** be included unless specifically requested.

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.

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

FULL NAME: ..... Date of birth:.....

Your GP practice is supporting Summary Care Records and as a patient you have a choice. Please tick in one of the boxes below to indicate your choice.

<input type="checkbox"/>	<b>Yes I would like a Summary Care Record</b> - you do not need to do anything and a Summary Care Record will be created for you
<input type="checkbox"/>	<b>No I do not want a Summary Care Record</b> – at the back of this booklet is an opt out form which you will need to complete and return to us
<input type="checkbox"/>	<b>Yes I would like a Summary Care Record which includes Additional Information</b> - you do not need to do anything and a Summary Care Record with Additional Information will be created for you

**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.

For more information visit [www.hscic.gov.uk/scrpatients](http://www.hscic.gov.uk/scrpatients) or phone the Health and Social care Information Centre on 0300 303 5678.



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)..... Signature .....

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 question, or if you want to discuss your choices, please:

- Phone the Summary Care Record Information Line on 0845 300 6016 Option 2
• Contact your local Patient Advice Liaison Service (PALS) or
• Contact your GP practice.

FOR NHS USE ONLY

Actioned by practice : yes / no

Date .....