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 Previous doctor whilst at that address

....

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

Your first address in UK

.....

Date you left the UK ..... Date you returned to the UK .....

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

Date you first came to the UK .....

Are you now "Ordinarily Resident" in the UK?* ☐ Yes ☐ No - we will be in touch to ask you further questions

**Ordinarily Resident means, broadly speaking, that you are living in the UK lawfully for a settled purpose for the time being. You will be asked to prove this.*

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

Date of Enlisting **___/___/___** Service/Personnel Number.....

Address **before** enlisting .....

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

YOUR 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 ever suffered from any of the following medical conditions?

	Tick	*Age at onset*	*Details*
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			

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

Year of onset **Problem**

…… ……

…… ……

…… ……

…… ……

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.

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.

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

ELECTRONIC PRESCRIPTIONS

We can send your prescriptions direct to a pharmacy of your choice without the need for a paper prescription.

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:

Name of Drug/Medicine	**Date**	**Reaction**
.....	.....	.....
.....	.....	.....
.....	.....	.....

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

..... Date .....

..... Date .....

..... Date .....

Other(s) ..... Date(s) .....

1-year immunisations

..... Date(s) .....

..... Date(s) .....

..... Date(s) .....

Pre-School Booster

..... Date(s) .....

..... Date(s) .....

..... Date(s) .....

Other(s) ..... Date(s) .....

ETHNICITY

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

☐ White British	☐ Mixed White & Asian	☐ Bangladeshi / British
☐ Irish	☐ Other Mixed	☐ Other Asian
☐ Other White	☐ Chinese	☐ Caribbean
☐ Mixed White & Black Caribbean	☐ Indian / British	☐ African
☐ Mixed White & Black African	☐ Pakistani / British	☐ 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

☐ Any organs and tissue ☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to inclusion on the NHS Organ Donor Register ***Date ___ /___ /_____***

……

For more information, please 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 visit the website www.blood.co.uk, *or call 0300 123 23 23*

My preferred address for donation is*: (only if different from home address provided eg/your place of work)*

……. Postcode ……

NEXT OF KIN

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.

Please indicate if you are happy for your record to be discussed with them, if relevant.

Name	Contact number	Relationship	Can discuss your record?
			☐ Yes ☐ No
			☐ Yes ☐ No

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. Please indicate if you are happy for your record to be discussed with them, if relevant

Name	Contact number	Relationship	Can discuss your record?
			☐ Yes ☐ No
			☐ 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)

1 unit	***1.5 units***	***2 units***	***3 units***	***9 units***	***30 units***
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

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 if 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 come to Reception in person bringing your passport or photo driving licence. Once you have agreed to our Terms of Use we will issue a registration letter with codes that are just for you and instructions about how to complete your registration.*

Rectory Meadow Surgery Patient Group 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 _____