PAPERWORK REQUIRED FOR REGISTRATION

WE WOULD LIKE TO WELCOME YOU TO ADDINGTON MEDICAL CENTRE

To assist us with your registration please provide us with the following documentation between the hours of 10am to 5.00 pm

1. NHS Card (or NHS number – available from previous GP)

2. GMS1 Registration Form (included in this pack)

3. Proof of Identity - This can be any one of the following:
· Passport
· ID Card
· Photo Driver's Licence **(UK only)**

4. Proof of Address – 1 document confirming your address such as:
· Utility bill (gas, electricity, TV, telephone) dated within the last 3 months
· Bank or Building Society statement dated within the last 3 months

Your address must be within our designated Practice Area. Please note that we cannot accept utility bills in Company names only. The patient must be named on all documents provided.

5. New Patient Health Questionnaire (included in this pack)

CHILDREN

- The **red baby book** or other vaccination record is required for children.
- Children must be registered with a parent or guardian at the same address.

VISITORS FROM OVERSEAS

- To register as a patient the NHS requires overseas nationals who have entered the country to show proof of intended residency for a three month period or longer.
- Refugees or asylum seekers will have home office documentation
- Passport with a valid visa for six months or longer
- Patients from overseas can be registered as a TEMPORARY RESIDENT if they have an intention to be in the area for 24hrs – 3 month period.

If you have any queries in relation to the above please speak to one of our receptionists who will be happy to assist you, or visit our web-site at
www.addingtonmedicalcentre.co.uk

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

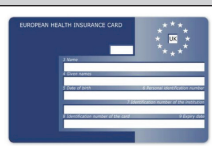
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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.

ADDINGTON MEDICAL CENTRE

NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. This information will only be used within the practice and will never be passed to other parties without your permission. By completing this form you are agreeing for this information to be entered on a computer database held by the practice. When completed please bring it to **The Addington Medical Centre** with your NHS card and make an appointment for a New Patient Health Check.

Name: Address: E-mail address:	Date of Birth: Home telephone: Work telephone: Mobile: Current occupation (or school):
Next of Kin Name: Address:	Relationship to you: Telephone:
Medical History Please list any serious illnesses or operations you have had:	**Medication** Please list all medication you take regularly or supply us with a copy of your repeat prescription sheet. **Allergies:** (please specify)

Smoking status: How many per day? _____ Ex-smoker ☐ Never smoked ☐

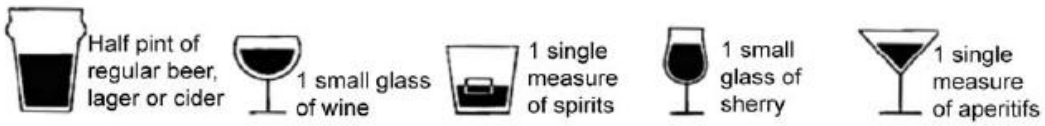
I would like to see a Smoking Cessation Advisor ☐

Alcohol intake: Units per week? _____ *(1 unit = ½ pint of beer or 1 measure of spirits or 1 glass of wine)*

Height:	**Weight:**
Chronic diseases: Do you suffer from any of the following? Heart disease ☐ Date: Stroke ☐ Date: Diabetes ☐ Date: Asthma ☐ Date: COPD/Emphysema ☐ Date: Epilepsy ☐ Date: Cancer (specify type) ☐ Date:	**Family History:** Does anyone in your family suffer from any of the following? - State which relative Heart disease under 60 ☐ _____ Heart disease over 60 ☐ _____ Stroke ☐ _____ Diabetes ☐ _____ Breast cancer under 50 ☐ _____ Bowel cancer under 50 ☐ _____
Women only: If required when do you think your next cervical smear test will be due? If required what contraception do you use?	**NHS Summary Care Record** (see details on web-site) ☐ I consent to allow a summary of my records to upload to the NHS Summary Care Record ☐ I do NOT consent to allow a summary of my records to upload to the NHS Summary Care Record
Are you a carer for someone who is elderly or disabled?	
Signature	**Date**

ALCOHOL QUESTIONNAIRE

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C (3 Questions)

Questions	Scoring system					Your score
	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
3. 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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C **positive**.

ETHNICITY

NAME _____

ADDRESS ----------

POST CODE ---------- **TEL NO** ----------

WHAT IS YOUR FIRST LANGUAGE? ----------

DO YOU NEED AN INTERPRETER? _____ **YES OR NO**

OFFICE USE (Read Code)	ETHNIC CATEGORY	TICK ONE BOX
	a) White	
9i0	British	☐
9i1	Irish	☐
9i2	Any other background	☐
	b) Mixed	
9i3	white and Black Caribbean	☐
9i4	white and Black African	☐
9i5	White and Asian	☐
9i6	Any other mixed background	☐
	c) Asian or Asian British	
9i7	Indian	☐
9i8	Pakistani	☐
9i9	Bangladeshi	☐
9iA	any other background	☐
	d) Black or Black British	
9iB	Caribbean	☐
9iC	African	☐
9iD	Any other Black background	☐
	e) Other ethnic Groups	
9iE	Chinese	☐
9iF	Any other ethnic group	☐
9iG	Not stated	☐

Addington Medical Centre

Dr. Andrew Painter
Dr. Minoti Patel
Dr. Gareth Dee
Dr. Ayodele Awe

46 Station Road
New Barnet
Herts
EN5 1QH

Tel: 020 8441 4425
Fax: 020 8441 4957

Contact authorisation form

Dear Patient,

If we need to communicate with you how would you prefer to be contacted?

Email [ ] Current email address (please print) ……

Text [ ] Your mobile phone number: ……..

Post [ ] Please ensure that we have your correct address on our records.

Please tick your preferred choice.

I understand that my GP practice will take all reasonable steps to keep my health information secure and private.

I agree to allow the use of email or text messages for Non-Urgent communication regarding health matters.

I will inform the practice if I change to a new GP practice or change address or contact details including my email address and mobile phone number.

Full name (please print) …….

Signed …….. Date:……

ADDINGTON MEDICAL CENTRE

Accessibility Information Standard

Dear Patient,

From 1st August 2016 onwards, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard.

The Standard aims to make sure that **people who have a disability, impairment or sensory loss** are provided with information that they can easily read and understand and with support so they can communicate effectively with health and social care services.

Please could you answer the following?

Do you have a disability, impairment or sensory loss which requires information or communication support?

YES ☐ NO ☐

If **YES** how can we as a surgery best meet your needs?

Eg: Do you need information in large print or easy to read format?

Do you need a British sign language interpreter or advocate?

_____

_____

_____

ADDINGTON MEDICAL CENTRE

ADVICE FOR PATIENTS ON RECEIVING TEXTS FROM ADDINGTON

Addington Medical Centre would like to text you to remind you of appointments or to book vaccines or to book a routine appointment for the doctor.

Examples of texts we might send you:

"According to our records you/your child is due childhood/flu/cervical smear…. Please contact the surgery on 02084414425 to arrange an appointment.
Addington Medical Centre would like to offer you smoking cessation advice, please call and book with our Health Care Assistant.
Please could you contact the surgery on 02084414425 following the results of your recent x-ray/blood test/scan/investigation/hospital visit/prescription and make a routine appointment."

Addington will never send you a text reminder if your appointment is urgent. We will phone you.

To opt in/opt out please sign the form below.

I understand that Addington will take all reasonable steps to keep my health information secure and private.

I agree/disagree to allow the use of text messages for non-urgent communication regarding health matters.

I will inform Addington if I change my mobile number or if I wish to opt out of text messaging.

Full Name (please print)……

Date of Birth ……

Signed …… Date ……

Appendix C

Review Jan 2019