BASSINGHAM SURGERY

Dr P Bridgwood
Dr M Hargreaves
Dr H Wilson
Mrs Juliet Brewer Practice Manager
01522 788250

Dear New Patient

WELCOME TO BASSINGHAM SURGERY

In your registration pack you will find

- A new patient registration form
- A new patient questionnaire, this helps us until we receive your medical records.
- A text messaging consent form, we use text messaging to confirm appointments have been booked and also to remind patients to attend their appointments
- A medication form

You can find useful information on our website www.bassinghamsurgery.co.uk

You should be aware that until we have received your medical records and they have been reviewed we will not be able to complete any insurance paperwork or offer you advice with regard to travel vaccinations.

Please note that repeat prescriptions cannot be issued to new patients unless they have been seen by a GP or Nurse Prescriber. If you are currently taking regular medication please ensure you have a months' supply from your previous surgery prior to handing in this application. You will then need to make an appointment with a GP to ensure that your medication is added onto our clinical system in time for your next prescription to be issued.

Please complete the form relating to your medication.

Thank you for your co-operation in completing the attached documentation.

We trust you will be happy with the services we provide.

Yours sincerely

Juliet Brewer
Practice Manager

New patient registration

IMPORTANT

Once you have handed your forms in at Bassingham Surgery, please allow at least 3 working days for the registration to be processed, a text will be sent to you to confirm your registration, at which point you should be able to ring for an appointment should you need to.

Any patient over 18 can book in for a New Patient check, this is a 20 min appointment with a Health Care Assistant and includes taking a brief medical history and lifestyle questions. Please speak to Reception if you would like to book an appointment.

Please be aware if forms are filled in incorrectly or information is missing your registration may be delayed.

SHARING MEDICAL RECORDS

Please read each statement and mark Yes or No and sign below to confirm your preferences.

I consent to Bassingham Surgery sharing my medical record with other medical organisations that use the SystmOne computer system. **Yes No**

I consent to Bassingham Surgery receiving medical information from other medical organisations that use the SystmOne computer system. **Yes No**

Signed ______________________________ Date ______________

YOUR EMAIL ADDRESS ______________________________________

May we include your email address in our patient reference group database? This is for Bassingham Surgery only and will involve us occasionally contacting you by email with a short survey (no more than two a year)

YES NO Signed ______________________________

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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: .... Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ 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

Signature confirming my consent to join the NHS Organ Donor Register Date ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register Date ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

052019_006 Product Code: GMS1

WHO IS YOUR NEXT OF KIN? ______________________________

How are they related to you?____________________ A contact number for them __________________

ARE YOU A CARER? YES NO
If yes who do you care for? ______________________________

DO YOU SMOKE? YES NEVER SMOKED EX SMOKER

If yes, would you like advice to help to stop? **YES NO**

DO YOU DRINK ALCOHOL YES NO IF YES HOW MUCH PER WEEK? ______________________

HOW MUCH DO YOU WEIGH? ____________________ **HOW TALL ARE YOU?** __________________

DO YOU HAVE ANY HISTORY OF THE FOLLOWING?

HEART DISEASE	**YES NO**	DIABETES	**YES NO**
ASTHMA	**YES NO**	HYPERTENSION	**YES NO**

OR ANY FAMILY HISTORY OF THE ABOVE? PLEASE GIVE DETAILS BELOW

____

____

HAVE YOU EVER HAD	A FLU VACCINATION?	**YES NO**
	A PNEUMONIA VACCINATION?	**YES NO**

IS THERE ANYTHING ELSE YOU THINK WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY?
IF SO PLEASE GIVE DETAILS eg. Operations, Serious Illness ie Hepatitis b, Hepatitis c, HIV or Aids or Allergies.

____

____

PLEASE INDICATE YOUR ETHNIC ORIGIN BELOW

WHITE	**BRITISH/IRISH/OTHER** ______________________
MIXED	**WHITE AND BLACK CARIBBEAN/WHITE AND ASIAN/OTHER** __________
ASIAN OR ASIAN BRITISH	**INDIAN/PAKISTANI/BANGLADESHI/OTHER** ______________
BLACK OR BLACK BRITISH	**CARIBBEAN/AFRICAN/WHITE AND ASIAN/OTHER** ____________
CHINESE OR OTHER ORIGIN	**CHINESE/OTHER** ________________________

FEMALE PATIENTS 25- 65 YEARS

WHEN WAS YOUR LAST CERVICAL SMEAR? ______________________

WHAT METHOD OF CONTRACEPTION DO YOU USE? ________________

SystmOnline

If you would like to access your online record – to order repeat prescriptions, to link your NHS App or to view your available medical history, please speak to one of our Receptionists. (photo ID required)

TEXT MESSAGING CONSENT

Please fill in your details and read the policy below carefully before signing

Name of patient	**Date of birth**
NHS number	
Mobile tel No	
Parent/guardian name if patient is under the age of 16. Please state relationship	

I would like to receive text messages to the above mobile telephone from Bassingham Surgery and understand that the content will only relate to the medical record belonging to myself/my child. It may include confirmation of an appointment, a reminder alert or short messages from the Doctor/Surgery.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing, quoting the above mobile number.

Text messages may be sent to a parent/guardian if the child is under 16 years of age.

I am aware that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed.

I confirm that I understand the details above and that I am the patient listed above. I understand that it is my responsibility to advise Bassingham Surgery of any changes to my mobile telephone number.

Signature ________________________________ **Date** ____________________

Form must be signed by the named patient unless the patient is a child under the age of 16 years.

MEDICATION DETAILS

Please list below your current repeat medication

PLEASE NOTE THIS MEDICATION CANNOT BE ISSUED UNTIL YOU HAVE BEEN SEEN BY A CLINICIAN AT THIS SURGERY. PLEASE ENSURE YOU HAVE A MONTHS WORTH OF MEDICATION BEFORE SUBMITTING THIS FORM.

ELECTRONIC PRESCRIBING

If you live outside our Dispensing area (Witham St Hughs or Navenby) and would like to nominate a Pharmacy to have your prescriptions sent to electronically, please indicate below your preferred Pharmacy. **Please put full pharmacy name, address and post code.**

Admin Only

New patient appointment made? Yes / No

Date -
Time -
Clinician -