BERMUDA & MARLOWE PRACTICE

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NEW PATIENT REGISTRATION PACK

Welcome to Bermuda & Marlowe Practice

To register with the Practice please complete the attached forms.

If you have already completed these forms online please advise the Receptionist who will print off the forms for you, ask you to sign them and check your identification.

1. **The NHS Family Doctor Services Registration Form GMS1 (the smaller form)**
   This is an NHS form used by all Practices when registering with a GP and is your official declaration of your current status.
2. **The Bermuda & Marlowe New Patient Medical Registration Form**
   This is a more detailed form which tells us about you and your medical history. It enables us to trace your previous medical records from your previous UK GP if you have one. Paper records will be traced by the Primary Care Support England Registration Department and forwarded to us as soon as possible. Electronic records, in the majority of cases, will transfer electronically via a system called "GP2GP". However this can depend on your previous Practice and when you were last seen. GP2GP only applies to Practices in England - other parts of the UK do not use it.
3. **The Child Transfer In Form** (patients aged under 16 only)

DO NOT COMPLETE THESE FORMS FOR BABIES – PLEASE ASK FOR A BABY REGISTRATION FORM

PLEASE HELP US BY COMPLETING ALL THE INFORMATION. This avoids us having to contact you to obtain missing information and possibly delay your registration.

IDENTIFICATION

- **For patients aged 16 or over** we will require TWO forms of identification.
  Please provide one form of I.D. from section 1 and one form of I.D. from section 2 below.

1. Photo I.D. e.g. UK Driving Licence, Passport, or Proof of Age Card
2. Proof of your address. This is because registration is based solely on residency within our catchment area. Proof of address can be a Bank or Savings Account Statement, Utility Bill, Council Tax Bill, Housing letter from the Council or Housing Association, National Insurance Letter.
   The document should show your name and address.

Driving Licence is acceptable as combined proof for both sections 1 and 2 above if it shows your current UK address. The other forms of I.D. listed in section 2 above should show your **current address** and be no more than 3 months old.

- **For patients aged under 16** we require a copy of their birth certificate only
- **For newborn babies** we require a copy of their birth certificate or red book

THANK YOU

Also available – please ask Reception for details:

- **Online Access to Medical Records Application Form**
- **Online Proxy Access to Medical Records Application Form (to give access to another person)**

NEW PATIENT MEDICAL REGISTRATION FORM - CONFIDENTIAL

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

First Names (in full)

Previous Surnames

Date of Birth (day/month/year)

NHS Number ☐☐☐ ☐☐☐ ☐☐☐☐

Gender ☐ Male ☐ Female

Religion

Marital status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Cohabiting

Ethnicity - please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani

☐ Bangladeshi ☐ Chinese ☐ Decline to state

☐ Other (please state):

Main Language

Do you require the help of a Translator / Interpreter? ☐ Yes ☐ No

Address

Post Code:

Residential Status
e.g. independent, residential home, nursing home

Are there any specific access instructions? e.g. key code

Occupation

Telephone numbers

Home: Work: Mobile:

Email address:

Do you have a previous UK address? ☐ Yes ☐ No

If yes, your previous address in UK

Post Code:

Consent to text and email correspondence: ***(please see attached full consent form for details)***

Where you have provided information on how to contact you, can you confirm you are happy for Bermuda & Marlowe Practice to contact you by the following:

By text (SMS) ☐ Yes ☐ No This will be to send you reminders of appointments via text.

By email ☐ Yes ☐ No This will be to send you letters, newsletter, etc.

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

Town & Country of Birth

Name of previous Doctor while at previous address

Address of previous Doctor

Post Code:

Where did you last receive treatment? e.g. GP, Walk in Centre, Emergency Dept

Date:

What was the outcome of this visit? e.g. prescription

If you are from abroad:

Have you registered with a GP in the UK before? ☐ Yes ☐ No

If yes, your first UK address where registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK*

**** The date you first came to the UK is really important as it tell us whether or not you have medical records at a Practice in the UK before registering with us.***

If you are returning from the Armed Forces:

Addresss before enlisting

Post Code:

Enlistment date:

Service / Personnel No:

Date of Discharge:

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No **Do you have a carer?** ☐ Yes ☐ No

If you have a carer please tell us the name, address and tel number of your Carer:

Post Code:

Telephone Number:

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

Next of kin ……

Name: **Tel. Number:**

Relationship: e.g. wife/husband/partner/son/daughter

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Department, Out of Hours Service). The NHS Summary Care record is an electronic record of information about your health. It will be available to health care staff providing your NHS care.

Are you happy to have a core Summary Care Record? ☐ Yes ☐ No
(Core Record - Medications/allergies/adverse reactions only)

Are you happy to have a core AND additional Summary Care Record? ☐ Yes ☐ No
(*Enhanced Record - Medications/allergies/adverse reactions*
AND Diagnoses/Treatments/Results/Carer and Social and Personal Information)

Do you wish to share your medical information with a 3rd party? ☐ Yes ☐ No
This will be recorded on your notes and is your permission to speak to this person about your health

If yes:
Name: **Tel. Number:**

Relationship: e.g. wife/husband/partner/son/daughter

Personal Medical History…..

Lifestyle smoking ……

Do you smoke? ☐ Yes ☐ No If "No" have you ever smoked? ☐ Yes ☐ No

If "Yes" do you smoke: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Rolls own ☐ Other

If you smoke cigarettes / cigars how many do you smoke daily?

☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Are you an ex-smoker? ☐ Yes ☐ No If "Yes" when did you give up?

If you used to smoke cigarettes / cigars how many did you smoke daily?

☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you used to smoke a pipe how many ounces a week?

Do you currently use chewing tobacco? ☐ Yes ☐ No If "Yes" how many grams a week?

Do you currently use an E-cigarette? ☐ Yes ☐ No

Would you like help to quit smoking? ☐ Yes ☐ No

Blood Pressure……

Please use the blood pressure machine in our waiting area to take your blood pressure and write the result in the boxes provided:

e.g. 117 56 mmHg SYS ☐ (117) DIA ☐ (56)

Lifestyle alcohol ……

Do you drink alcohol? ☐ Yes ☐ No If "Yes" please answer the following questions:

How many **UNITS** of alcohol do you drink each week? *(note that one drink does not equal one unit)*

*The number of **UNITS** you are drinking depends on the size **and** strength of your drink e.g.:*

DRINK	SIZE	STRENGTH (ABV)	UNITS	SIZE	STRENGTH (ABV)	UNITS
Beer/Lager/Cider	Pint	3.8%	2.2	Pint	5.2%	3
Wine	Medium 175ml glass	11%	2	Large 250ml glass	14%	3.5
Wine	Bottle	11%	8.2	Bottle	14%	10.5

☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8

☐ 10+ ☐ 15+ ☐ 20+ ☐ 30+

How many alcoholic drinks do you have on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 10+

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Lifestyle exercise ……

What is your current exercise status?

☐ Impossible ☐ Avoid ☐ Light ☐ Moderate ☐ Heavy ☐ Competitive

Please enter your weight & height: *(Reception – use EMIS to calculate BMI)*

Weight (kg): ☐ Height (cm): ☐

Disabilities……

Are you registered blind? ☐ Yes ☐ No

Are you registered partially sighted? ☐ Yes ☐ No

Do you have hearing difficulty? ☐ Yes ☐ No Or deafness? ☐ Yes ☐ No

Are you dependent on a wheelchair? ☐ Yes ☐ No

Do you have any problem with speech? ☐ Yes ☐ No

Do you have any other disability? ☐ Yes ☐ No

If "yes" please state ☐

Family History……

Have any relatives ever suffered from any of the following? (please indicate who in the boxes)
e.g. mother, father, sister, brother, aunt, uncle, maternal grandmother, maternal grandfather, paternal grandmother, paternal grandfather (if more than one family member, list all)

Heart diseased aged under 60	Heart Disease aged 60+	Heart attack
Asthma	High blood pressure	Diabetes
Stroke	Rheumatoid Arthritis	Cancer
Glaucoma		

Allergies ……

Please list any allergies you have (including allergies to medications):

I am allergic to	**What was the problem or upset?**

Pregnancy/Contraception/Smear History (FOR FEMALE PATIENTS ONLY)……

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No If yes, how many?

Which method of contraception (if any) are you using at present?

Have you had a cervical smear test? ☐ Yes ☐ No If yes, what was the result? (if known)

Date (if known)

Your Health …… (Sections from this point forward are for all patients)

Have you ever suffered from any important medical illness, operation or admission to hospital?
If so please enter details below:

Condition	Year diagnosed	Ongoing
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Did your previous GP create a care plan for you?
e.g. mental health care plan or admissions avoidance care plan? ☐ Yes ☐ No

List of current medication ……

☐ I am not on any medication

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

ELECTRONIC PRESCRIPTION SERVICE (EPS) - *Please see attached information (page 10) for full details*

Would you like your prescription sent electronically to a Pharmacy of your choice? ☐ Yes ☐ No

If yes, which Pharmacy would you like to nominate? *(Name and location)*

(Please note that in order to change your nominated Pharmacy, you will need to let your current nomination know)

Specific needs ……

Please detail below any specific needs you have, that you have not already stated above, so the Practice can ensure they are identified and accommodated by taking the appropriate action	
Do you have any other communication or information needs relating to a disability or sensory loss? If so, what are they?	
Are you an 'Assistance Dog' User?	
Please state any other Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises:	
Please state any Religious or Cultural needs:	
Do you require the use of a Hearing Loop?	
Do you have any special communication needs? If yes: ☐ Sign Language ☐ Large Print ☐ Other	If other, please state

Immunisations ……

If you have any printed information about previous immunisations, that is not already in your notes, please let us have a copy.

Immunisation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Organ and blood donation

Do you consent to being on the organ and tissue donor register? ☐ Yes ☐ No

Do you consent to being on the blood donor register? ☐ Yes ☐ No

Help us assess if you may need additional clinical input (FOR PATIENTS AGED 85 OR OVER)……

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐ No

In general, do you have any health problems that require you to stay at home? ☐ Yes ☐ No

Do you regularly use a stick, walker or wheelchair to get about? ☐ Yes ☐ No

In case of need, can you count on someone close to you? ☐ Yes ☐ No

Do you need someone to help you on a regular basis? ☐ Yes ☐ No

Please provide details if the person is different from the information you have provided as your carer.

Name: **Tel. Number:**

Relationship: e.g. wife/husband/partner/son/daughter

SIGNATURE …… Have you completed all sections of this registration form?
Please avoid us having to contact you to obtain missing information.

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐

PRACTICE USE ONLY - *this section to be completed by Receptionist accepting this form from the patient*	
• **Patients aged 16 or over**: Two forms of identification are required, one each from section 1 and section 2 below. Driving Licence is acceptable for both sections if it shows current UK address. Other forms of I.D. listed in section 2 should show patient's current address and be no more than 3 months old	
1. Photo I.D. checked	☐ UK Driving Licence ☐ Passport ☐ Proof of Age Card
2. Proof of address checked	☐ UK Driving Licence ☐ Bank Statement ☐ Utility Bill ☐ Council Tax Bill ☐ Council Housing or Housing Association Letter ☐ National Insurance Letter
• **Patients aged under 16**	☐ Copy of birth certificate only
☐ EMIS Registration completed	☐ QMasters "New Patient" Template completed on EMIS
Checked and Completed by (Receptionist Name)	Date
☐ Receptionist to Scan completed form to patient's medical records	

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TELEPHONE / MOBILE PHONE / TEXT (SMS) MESSAGE / E-MAIL - PATIENT CONSENT

Name		**Date of Birth**	
Telephone Number		**Mobile Number**	
Email address			

I agree to the Practice using the following methods in order to contact me: *(tick all that apply)*

☐ Telephone Number ☐ Mobile Number (calls & text SMS) ☐ Email

Signed:

The GP Practice will on occasion wish to contact you in order to notify you of such circumstances as appointment confirmations and reminders, changes to your booked appointment, national issues such as Flu pandemics, the GP Practice being closed due to unforeseen circumstances etc. This may be in the form of a phone call, text (SMS) message or email. Information sent via text (SMS) is from a number of packages including "MJog", "allivia.com" and "accuRx Chain".

Disclaimer

If you agree to the GP Practice contacting you via your telephone number, mobile phone, or fixed land line number, the GP Practice agrees to adhere to the following:-

1. The mobile phone number, or fixed landline number will only be used by the GP Practice and will not be passed to any other parties.

2. If at any time you would like to opt out of either services, please make a personal request to the GP Practice and you will be opted out of the service within 48 hours. You may also like to include your reason for opting out, to help us review and improve the service in future.

3. Your mobile phone number will solely be used by the GP Practice in relation to the healthcare services offered by the GP Practice. You will not be contacted in relation to any other types of products or services.

4. You acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. You can cancel the text message facility at any time.

5. Text messages are generated using a secure facility. You understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the Practice will not transmit any information which would enable an individual to be identified.

6. You agree to advise the Practice if your mobile number changes or the mobile phone is no longer in my possession.

7. Emails are sent through the NHS email service. NHS email addresses are encrypted and secure. However messages sent via a public network to a personal email address may not be secure.

8. You agree to advise the Practice if your email address changes.

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ELECTRONIC PRESCRIPTION SERVICE (EPS) – PATIENT INFORMATION

An alternative way to get your repeat medicines and appliances

EPS is an NHS service which allows you to ask your GP to electronically send your prescription for repeat medicines or appliances directly to your preferred location e.g. your preferred pharmacy.

WHAT DOES THIS MEAN FOR YOU?

- If you collect your repeat prescriptions from your GP you will not have to visit your GP Practice to pick up your paper prescription. Instead, your GP will send it electronically to the place you choose, saving you time. **Note that you still need to request your medication each time you need it. Repeat prescriptions take 72 HOURS (excluding weekends and bank holidays) to process.**
- You will have more choice about where to get your medicines from because they can be collected from a pharmacy near to where you live, work or shop.
- You may not have to encounter a long wait at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive. *(If you are exempt from paying for prescriptions, or have a prepayment certificate, remember to take proof to your pharmacy.)*

IS THIS SERVICE RIGHT FOR YOU?

"YES" if you have a stable condition and you:

- Don't want to go to your GP Practice every time to collect your repeat prescription
- Collect your medicines from the same place most of the time
- Use a prescription collection service now

"NO" if you:

- Don't get prescriptions very often
- Pick up your medicines from different places
- Frequently travel or work away from home
- Have your prescriptions collected by your Pharmacy and dispensed via a dosette box

HOW CAN YOU USE EPS?

- **Apply for "Access to Online Services"** – please ask for an application form. Online access covers EPS/prescription requests, but also covers appointment booking and access to parts of your record.
- If you do not want "**Access to Online Services**" you can instead choose a place for your GP Practice to electronically send your prescription. This is called *nomination.* Please complete an "**EPS nomination slip"** to confirm your preferred location. You can choose:
  - A Pharmacy
  - A dispensing appliance contractor (if you use one)
- **You can also sign up at your chosen pharmacy and they will advise us.**

(If you are reading this information as part of registering as a new patient, you do not need to complete a nomination slip, but please ensure you have completed the EPS section on page 7 of the registration form)

CAN I CHANGE MY NOMINATION, OR CANCEL IT AND GET A PAPER PRESCRIPTION?

Yes you can. If you want to change your nomination for any reason, or the pharmacy cannot meet your requirements, please complete and sign a new nomination slip. You can only have one nominated pharmacy at a time. Please note that the preferred pharmacy location is **the patient's choice**. The Practice does not influence your choice of pharmacy and we will not become involved in disputes between Pharmacies.
If you no longer want your prescription to be sent electronically please also complete a nomination slip.

IS EPS RELIABLE, SECURE AND CONFIDENTIAL?

Yes. Your electronic prescription will be seen by the same people in GP Practices, pharmacies and NHS prescription payment and fraud agencies that see your paper prescription now. Sometimes dispensers may see that you have nominated another dispenser. For example, if you forget who you have nominated and ask them to check or, if you have nominated more than one dispenser.

For more information about EPS visit your pharmacy, dispensing appliance contractor or:
https://www.nhs.uk/using-the-nhs/nhs-services/pharmacies/electronic-prescription-service/