Cavendish Medical Practice

Registration Pack

Opening Hours:
Monday to Friday
8:00am – 6:30pm

Extended Opening Hours on Wednesday:
6.30pm - 8.00pm
Daytime Contact Number:

0121 203 2050
Outside Surgery Hours:
0121 7662100
NHS 111

Emergency Service:
999

Doctors:
Dr T Cheema
Dr K Cheema

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*

**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

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

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Patient Details

Title	Date of Birth
Surname	First Name(s)
Previous Surname(s)	Occupation
Address	Email
City	Telephone no.
Post Code	Mobile no.

From time to time we may need to contact you (Please see privacy notice). Please tick below to indicate how you prefer to be contacted.

☐ Phone ☐ Email ☐ Post

If you hare happy to receive health promotion and surgery updates, please tick here ☐

If you do not wish to be contacted at all, please tick here and discuss with a member of staff ☐

Previous GP

Name
Name of Practice
Address
City
Post Code

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Next of Kin

Name	Relationship
Address	
City	
Post Code	Telephone no.

Are you happy for the surgery to contact this person in an emergency?	☐
Does this person have legal power of attorney?	☐
If NoK for a relative is in a care home, is DoLs in place?	☐

Children

Name of Child(ren)	Date of Birth	Current Nursery/School	Disability?

Are you a carer for any other children? ☐	Do you have parental responsibility? ☐
Any history of Female Genital Mutilation (FGM)/cutting? ☐	Any previous involvement with Children's Social Care? ☐

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Ethnicity

White		British
		Irish
		Other (please specify)

Black or Black British		Caribbean
		African
		Other (please specify)

Asian or Asian British		Indian
		Pakistani
		Bangladeshi
		Chinese
		Other (please specify)

Mixed		White & Black Caribbean
		White & Black African
		White & Asian
		Other (please specify)

Eastern European		Polish
		Romanian
		Czech Republic
		Other (please specify)

Language

What is your first language?		Do you require an interpreter?	☐
Are you a refugee/asylum seeker?	☐	Are you new to the UK?	☐

Proof of Identity

☐ Passport ☐ Driving License ☐ Utility Bill ☐ Birth Certificate ☐ Other

Do you wish to sign up for access to your digital health record? ☐

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Disabilities

Are you a registered disable? If so, please give details

Medical Information

Please tick the box next to the medical condition that you have

Epilepsy		Blindness	
High Blood Pressure		Glaucoma	
Heart attack		Diabetes	
Stroke		Asthma	
Cancer		Depression	
Eczema		Other (please specify)	

Have you had a flu vaccination?	☐	Have you had a pneumonia vaccination?	☐
Have you ever had a cervical smear? If so, when was the last one?	☐		
Do you smoke? If so, how many per day?	☐	Would you like advice on giving up smoking?	☐
How much alcohol do you drink in a week?		Would you like support to reduce your alcohol intake?	☐

Please complete in BLOCK CAPITALS and tick the boxes (yes/no) where appropriate

Please list any current medication with their doses

Medication	Reason for taking	Dose

Are you allergic to any medications?	☐	If so, please give details	
Do you have any other allergies?	☐	If so, please give details	

Safeguarding

Have you ever experienced domestic abuse?	☐
Are you currently experiencing domestic abuse?	☐
Do you require any support?	☐

A Patient Participation Group (PPG) is a group of volunteer patients, the practice manager and one or more of the GPs from the practice. They meet on a regular basis to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice.

Would you be interested in joining our PPG? ☐

(If you ticked the box, please fill out the membership form)

Name (PRINT)	
Signature	Date

Patient Participation Group

A Patient Participation Group (PPG) is a group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. Meetings are held once every quarter at the practice, either face to face or remotely. If you are available and interested in joining us then please fill in the member sign up form below.

Member Sign-up

Name: _____

Address: _____

_____

Email: _____

Home Telephone: _____

Mobile Telephone: _____

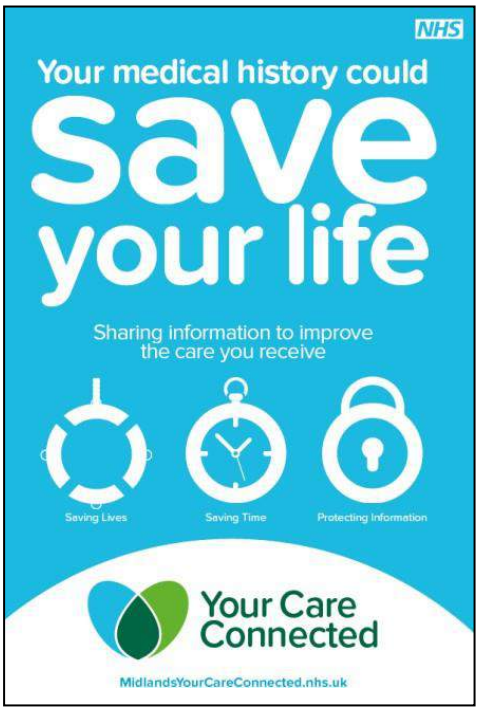
Please return completed forms to the Cavendish Medical Practice reception.

Your Care Connected

Website: www.MidlandsYourCareConnected.nhs.uk
Email: infoMidlandsYourCareConnected@nhs.net
Tel: 0333 150 3388 (Leave a voice message)

Your medical history could save your life

Your GP Practice is part of Your Care Connected (YCC), a potentially lifesaving NHS record sharing service, implemented across Birmingham, Sandwell and Solihull to provide better, safer care. If you need to attend a local hospital, YCC makes it possible for registered healthcare professionals caring for you to securely access important medical information from your GP record to provide you with better, safer care.



Your Care Connected will only be used to improve the care you receive when you visit one of the local NHS organisations across Birmingham, Sandwell and Solihull as listed on our website:

www.MidlandsYourCareConnected.nhs.uk

Your data will <u>not</u> be: extracted, stored elsewhere, used for research or marketing or sold to any other organisations. **If you opt-out of Your Care Connected, it will also automatically stop your record being shared for any other local record sharing projects** (for example, GP practice to practice sharing for extended opening hours and seven day access).

Your information, your choice

If you are happy to take part:

You do not need to do anything if you are happy to have your information accessed using Your Care Connected. If you visit one of the organisations listed on our website, those treating you will ask for your permission to view your record to help improve the care you receive.

If you <u>do not</u> want your information shared:

You will need to 'opt-out'. This will mean <u>only</u> your GP practice will be able to access your record. To 'opt-out', please complete the form below and give this back to your practice. Your practice will then process your request to turn off record sharing.

Opt out form: Only complete if you <u>do not</u> want your information shared

Please complete this form in BLOCK CAPITALS if you do not want your information to be shared using Your Care Connected for the purpose of improving your direct care when visiting one of the participating NHS organisations. If you wish to opt out on behalf of a child or vulnerable adult, you must request this from their registered GP practice by using this form. However they may decline your request if they believe it is not in the best interests of the child or vulnerable adult in question.

Title:_____ Name:_____

Date of Birth:_____ (DD/MM/YYYY) Postcode:_____ NHS No._____ (if known)

I do not want my information to be shared via Your Care Connected. I understand that this may mean important information will not be available to those treating me when making decisions about my treatment in potentially urgent and life-threatening situations. I understand that by opting out of Your Care Connected I will also opt out of any other local sharing initiatives by default. I also understand that if I change my mind I can only opt back in by visiting my GP Practice.

Signed:_____

Date: _____

FOR NHS USE ONLY
Date:
Actioned by:

Please complete and return to your GP practice.

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 questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....

Consent for Online Access to Medical Records Patients Form

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up the and operate the service.

The following form will take you through the things you need to think about. By signing the form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way. At the moment you can view allergies and immunisations. In the future more access may become available but you will not need to sign another access form but we may need to activate your records accordingly if you request to do so if more options becomes available.

Declaration (please circle choice as appropriate):

1. I agree to my GP practice giving me access to my record online.	YES / NO
2. I have read and understood the information about access to GP medical records.	YES / NO
3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.	YES / NO
4. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.	YES / NO
5. I agree that it is my responsibility to keep secure, my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.	YES / NO
6. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.	YES / NO
7. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*	YES / NO

Other considerations

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.	
8. If I notice any inaccuracies with my record, I will inform a senior member of staff or the practice manager as soon as possible of any errors or omissions.	YES/NO
9. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.	YES / NO
10. I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.	YES / NO

To be signed at reception by patient……..……..

Date……

<u>Please retain this copy of this form for your information.</u>
Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to a senior member of staff or the practice manager.

<u>For practice use only:</u>
ID checked documents…….Initials…….Date:……..

GP authorised:……Date:……

Medical Records Activated:……Date:……..

Accessible Information Needs Questionnaire

At *Cavendish Medical Practice* we want to make sure that we give you information in a way that is clear to you, and to have on record any communication needs you might have.

The NHS Accessible Information Standard aims to ensure those patients and their carers who have a disability, impairment or sensory loss can receive access and understand information and that they receive professional communication support if they need it.

This questionnaire has been designed to give you the opportunity to inform us if you have any difficultly in reading or understanding the information that we send you and record your preferred way of communicating with the surgery and its staff.

	Question	Please tick	
1.	Do you have any communication or information needs which are related to a disability, impairment, sensory loss or learning disability?	Yes	
		No	
2.	When we write to you or contact you, do you need us to communicate in a particular way?	Yes	
		No	

If your answer is **no** to both questions one and two, **please sign and date** the form and return to the reception staff. If yes, please complete the rest of this form.

	Question	Answer
3.	What disability, impairment, sensory loss do you have that affects your communication or information needs?	

Please choose your preferred method for us to contact you with information, such as a letter to invite you in for a flu vaccination:

Method or Format	Please tick or provide details
Text (please confirm the number)	
Email (please confirm your email address)	
Braille	
Easy read document	
Other (please tell us what this is)	

Question	Please tick	
When you come into surgery for an appointment do you need a British Sign Language interpreter? (13O85)	Yes	
	No	
Can we share this information with other health and social care providers (for example if you needed to attend an outpatient clinic at hospital)?	Yes	
	No	

Thank you for completing this form, please return it to the reception. We will update your patient records so that every time you book an appointment or we need to contact you we will do so using your preferred method.

You can find more information about the NHS Accessible Information Standard on NHS England's website https://www.england.nhs.uk/ourwork/patients/accessibleinfo/

Signature	Date

Checklist for New Patient Registration

- ☐ New patient registration form (GMS1)
- ☐ PPG registration form
- ☐ Sign up for digital health record

  Accessible Information Questionnaire
- ☐ Practice leaflet
- ☐ Patient charter
- ☐ Electronic prescriptions consent form
- ☐ Carer pack (if carer)
- ☐ Under 5 HV form filled (if under 5)