

## Welcome to our Practice

Thank you for registering with us. Our aim is to provide services and facilities that will contribute towards a healthy future for you. As part of the registration process we ask you complete the enclosed pack – this will give us all of the information we need to ensure we have everything we need to provide you with the care you want and need.

Once you have completed all of the enclosed documents, please return this to the Practice along with two forms of identification (at least one of which must have a photo **and** current address – like a driving license – and the other must be either Photo ID or Address verification – a passport or recent utility bill).

Please complete all sections in **BLOCK CAPITALS**.

(Please be aware that this document is “double-sided”)

<b>1.</b>	<b>Personal Details</b>		
First Name		Sex at birth	<input type="checkbox"/> Male
Middle Name(s)			<input type="checkbox"/> Female
Surname		Date of Birth	
Address			Postcode

<b>Parental Responsibility</b> – please provide birth certificate or court order to confirm			
Mother		Father	
Full Name		Full Name	
Date of Birth		Date of Birth	
Address		Address	
Next of Kin?		Next of Kin?	
Telephone No		Telephone No	
Residents at address (above)	Please list all individuals who share your home. Please include relatives, friends and lodgers (including part-time or temporary)		
Full Name	Relationship	DOB	Patient of Practice?
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
Please continue on a separate sheet of paper if necessary			

Childcare	Will any individual (not named as a joint resident of the address above) be providing childcare to the patient? (Nanny / Au Pair / friends etc) You do not need to provide information about a Nurse, Ofsted registered childminder or school in this section.	
	Yes – list full name(s) <input type="checkbox"/>	
	No <input type="checkbox"/>	

## 2. Communication Preferences

### Important Information

*It is practice policy to only record mobile telephone numbers and email addresses for patients over the age of 16.*

*The information entered should be that of a person (or people) with Parental Responsibility.*

*The practice will not use the SMS or email addresses provided to send appointment confirmation.*

Communication Type	Telephone Number	Consent for SMS / Email
Mobile Telephone		<b>Not applicable</b>
Landline Telephone		
Email Address		

Please specify which method you would prefer to receive communications via:

Landline <input type="checkbox"/>	Mobile (call only) <input type="checkbox"/>	<b>Please only select one option</b>
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To reduce the use of paper, the practice will only send letters to patients where an alternative method (email, call or text) would be unsuitable.

Communication via letter will always be sent to your registered address.

### Declaration

The above contact information is mine, or I have consent from the individual whose details I have given	<input type="checkbox"/>		
I accept that SMS / Email messaging is an additional service and may not be sent on all occasions	<input type="checkbox"/>		
I acknowledge that responsibility for attending / cancelling my appointments rests solely with me	<input type="checkbox"/>		
I take responsibility to ensure that my contact information is kept up to date with the Practice	<input type="checkbox"/>		
I give my permission for Answerphone Messages to be left on my Mobile / Landline telephone	<input type="checkbox"/>		
Full Name		Date	
Signature		Tick if you signed on patient's behalf	<input type="checkbox"/>

## 3. Background Information

Previous GP Name	
Previous GP address:	
Country of Birth	

Ethnic Origin	White (British) <input type="checkbox"/>	Chinese <input type="checkbox"/>	Black (African) <input type="checkbox"/>	Black (Caribbean) <input type="checkbox"/>
	White (Other) <input type="checkbox"/>	Indian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Pakistani <input type="checkbox"/>
	Arabic <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>	Other (specify)	

Religion	C of E <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Sikh <input type="checkbox"/>	Atheist <input type="checkbox"/>
	Catholic <input type="checkbox"/>	Muslim <input type="checkbox"/>	Jewish <input type="checkbox"/>	Hindu <input type="checkbox"/>
	Jehovah's Witness <input type="checkbox"/>	Other Christian <input type="checkbox"/>	Other (please specify)	

Living Accommodation	House <input type="checkbox"/>	Bungalow <input type="checkbox"/>	Ground Floor Flat <input type="checkbox"/>	
	Mobile Home <input type="checkbox"/>	Bedsit <input type="checkbox"/>	Upper Floor Flat <input type="checkbox"/>	
	Lodging <input type="checkbox"/>	Temporary <input type="checkbox"/>	Residential Home <input type="checkbox"/>	
	Homeless <input type="checkbox"/>	Nursing Home <input type="checkbox"/>	Warden-attended <input type="checkbox"/>	
With whom do you live?	Family <input type="checkbox"/>	Other Relatives <input type="checkbox"/>	Carer <input type="checkbox"/>	Guardian <input type="checkbox"/>

Are you able to walk independently?	Yes <input type="checkbox"/>	Walk without difficulty <input type="checkbox"/>	Walk with Mobility Aids <input type="checkbox"/>
	Aid(s) used <input type="checkbox"/>	Walking Stick <input type="checkbox"/>	Zimmer Frame <input type="checkbox"/>
		Crutches <input type="checkbox"/>	Walking Frame <input type="checkbox"/>
	No <input type="checkbox"/>	Walk with assistance <input type="checkbox"/>	Confined to chair <input type="checkbox"/>
		Unable to walk at all <input type="checkbox"/>	Bed-ridden <input type="checkbox"/>
Do you use a Wheelchair?	Yes <input type="checkbox"/>	If yes, what type of Wheelchair do you use?	Self-propelled Wheelchair <input type="checkbox"/>
	No <input type="checkbox"/>		Wheelchair pushed by another <input type="checkbox"/>
			Motorised Wheelchair <input type="checkbox"/>

Employment	Student <input type="checkbox"/>	Other (specify)
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<b>4.</b>	<b>Language &amp; Communication</b>			
Language	First Language			
	Second Language(s)			
	Do you have any communication needs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<b>Communicating with you</b> We want to communicate with you effectively, regardless of any difficulties you have in understanding how our letters, leaflets and other material is provided.				
When we write to you or contact you, do you need us to communicate in a particular way?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If your answer is "Yes", please tell us how using the boxes below. You may tick more than one box, but please make your preference clear.				
Communication	Hearing Loop <input type="checkbox"/>	Large Print <input type="checkbox"/>	Makaton Sign Language <input type="checkbox"/>	
	"Easy-Read" <input type="checkbox"/>	Braille <input type="checkbox"/>	British Sign Language <input type="checkbox"/>	
	Translation <input type="checkbox"/>	From English to:		

<b>5. Carers</b>		
Please read the guidance note "Carers" (page 4) before completing this section:		
Are you a Carer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name of the person for whom you care		
Relationship to you	Spouse <input type="checkbox"/>	Neighbour <input type="checkbox"/>
	Friend <input type="checkbox"/>	Other <input type="checkbox"/>
Are they a registered patient of the Three Chequers Medical Practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Guidance Note – Carers**

A Carer is someone who provides day-to-day help for another who would not be able to manage without that help.

Is there someone who relies on you to be that person so much so that, if you went away for a day or two, they wouldn't cope? If so, then **you are a carer**.

At Three Chequers Medical Practice, we want to support carers in whatever way we can.

It could be a friend, neighbour, or family member, but as a carer you play a vital role in, not only their life, but also the wider community and we want to know about the carers in our community so that we can keep you updated about all of the events, activities and support we can provide, or can support you to find.

Our practice lead coordinates all of our activities and events for carers and can give you advice or support depending on your situation. Contact the practice for more information.



<b>6. Medical History</b>		
Have you ever suffered from any of the following conditions?		
Asthma <input type="checkbox"/>	Cancer (information below) <input type="checkbox"/>	COPD <input type="checkbox"/>
Depression <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	High-Blood Pressure <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Underactive Thyroid <input type="checkbox"/>
Any other conditions, operations or hospital admissions or further information should be recorded below:		

Family History – please record any significant family history of close relatives with medical problems and confirm which relative it refers to (Mother, Father, Sibling etc)		
Asthma <input type="checkbox"/>	Cancer (information below) <input type="checkbox"/>	COPD <input type="checkbox"/>
Depression <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	High-Blood Pressure <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Underactive Thyroid <input type="checkbox"/>
Use this space to record which relatives any medical problem relates to and give further information:		

Allergies – Please record known allergies or sensitivities below:

Current Medication – please provide a list of medication in the space below. If possible, please attach a copy of your most recent prescription

### Immunisation History

Age Due	Immunisation	Comments	Batch #	Date given
2 months	Diphtheria / Tetanus / Polio / Whooping Cough / HiB/ Hep B			
	Rotavirus			
	Meningitis B			
3 months	Diphtheria / Tetanus / Polio / Whooping Cough / HiB/ Hep B			
	2 <sup>nd</sup> Dose Diphtheria / Tetanus / Whooping Cough			
	Rotavirus			
	Pneumococcal			
4 months	Diphtheria / Tetanus / Polio / Whooping Cough / HiB/ Hep B			
	Meningitis B			
12 to 13 months	HiB / Meningitis C			
	Measles, Mumps & Reubella (MMR)			
	Pneumococcal			
	Meningitis B			
3 years 4 months	Measles, Mumps & Reubella (MMR)			
	Diphtheria / Tetanus / Polio / Whooping Cough			
Teenage Vaccines	HPV (2 doses, 6 to 24 months apart) – Females only			
	Diphtheria / Tetanus / Polio			
	Meningitis ACWY			

Please give details of any other immunisations given (BCG etc)

<b>7.</b>	<b>Lifestyle</b>				
Smoking					
Do you Smoke?	Never <input type="checkbox"/>		Ex-Smoker <input type="checkbox"/>		Yes <input type="checkbox"/>
If you smoke or are an ex-smoker, how many do (did) you smoke per day	1 or less	2 to 9	10 to 19	20 to 39	40+
Do you Vape or e-Cigarette?	Never <input type="checkbox"/>		Ex-Smoker <input type="checkbox"/>		Yes <input type="checkbox"/>
Would you like help giving up smoking?			No <input type="checkbox"/>		Yes <input type="checkbox"/>

Height & Weight	
Height	Cm / Feet & Inches (delete as appropriate)
Weight	Stones & Pounds / Kg (delete as appropriate)

<b>8.</b>	<b>Prescriptions</b>
Please read the guidance note "Dispensing Medicine" for more information	

### Guidance Note – Dispensing Medicines

We are a Dispensing Practice – this means we can dispense medication to some of our patients, depending on the reason or where they live.

Our main dispensary is in Porton, with a secondary dispensary located in Winterslow to serve the communities of these villages. We also have a small dispensary in our Endless Street branch for urgent prescription fulfilment.

Our dispensers receive excellent training and work exceptionally hard, ensuring that repeat-prescriptions and urgent prescriptions are dealt with in a timely manner.

If you normally pay for your prescriptions, you will still have to do so, prior to collecting your prescription. We take card and cash at all of our dispensaries.

As a general rule of thumb, if you live in one of the following villages, we are able to dispense medicine to you:

Alderbury	Firsdon	Netton	Upper Woodford
Bodenham	Gomeldon	Nunton	Whaddon
Coombe Bissett	Homington	Odstock	Winterbourne Dauntsey
Durnford	Hurdcott	Pitton	Winterbourne Earls
East / West Grimstead	Lower Woodford	Porton	Winterbourne Gunner
Farley	Middle Woodford	Salterton	Winterslow

For patients living in these areas there are a few options on how you collect your medication; you can pop into your chosen Dispensary to collect your medicine; collect from one of our nominated "Collection Points" (Pitton Post Office / Alderbury Shop / Whaddon Post Office / Coombe Bissett Stores); or, if you're housebound, we can deliver the medicine to your door.

We aim to have all repeat prescriptions dispensed within 4 working days of receipt during peak times.

Our Dispensary relies on the support of the village communities in order to survive, please use our service if you are eligible. Eligible prescriptions sent to a Pharmacy or online service threatens the long-term viability of our Dispensaries and your support is greatly appreciated.

If you are not eligible, or if you wish to, you can opt to have your prescriptions sent to another Pharmacy. Please give details of this in Section 9 of the Application Pack.

All patients of the Practice suffering from a Long-Term Medical Condition or receiving a repeat prescription must undertake an annual review of the Medical Condition(s) and medication with the Practice. This is to ensure that you are receiving the appropriate care.



Are you eligible to receive prescriptions dispensed by the Practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, would you like the Practice to dispense your prescriptions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, which surgery would you like to collect your medicine from?	Porton & Old Sarum Surgery <input type="checkbox"/>	Winterslow Surgery <input type="checkbox"/>
Electronic Prescribing		
If you are not eligible for Practice Dispensing, would you like the Practice to send your prescriptions electronically?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pharmacy Name & Location		
I understand that I will have to undertake annual reviews of all Medicine I take <input type="checkbox"/>		

<b>9. Further Details</b>
Organ Donor Register
<p>From Spring 2020, legislation changed so that everyone in England is automatically registered as an Organ Donor.</p> <p>Please be aware that the Practice can not register you decision to opt out of organ donation.</p> <p>If you wish to, you can "Opt-out" by going to: <a href="http://www.organdonation.nhs.uk">www.organdonation.nhs.uk</a></p>

<b>10. Sharing Consent</b>			
<p>The Practice takes its responsibility under the Data Protection Act 2018 very seriously and wants you to make informed decisions about how your details are shared.</p> <p>Please take a few moments to read the guidance "Sharing your Health Record" before continuing to provide consent.</p> <p>After you have read the guidance note and understood the information, you will be asked to provide consent for sharing your information</p>			
I have read and understood the guidance (following page) entitled "Sharing your Health Record" <input type="checkbox"/>			
<p>Do you consent to your GP Practice sharing your Health Record with other organisations who care for you?</p> <p>Yes (this is the recommended option) <input type="checkbox"/></p> <p>No (not recommended, please discuss this with a GP before deciding) <input type="checkbox"/></p>			
<p>Do you consent to your GP practice viewing your Health Record from other organisations that care for you?</p> <p>Yes (this is the recommended option) <input type="checkbox"/></p> <p>No (not recommended, please discuss this with a GP before deciding) <input type="checkbox"/></p>			
<p>Do you consent to having an Enhanced Summary Care Record (SCR) with additional information?</p> <p>Yes (this is the recommended option) <input type="checkbox"/></p> <p>No (not recommended, please discuss this with a GP before deciding) <input type="checkbox"/></p>			
Full Name (print)			
Signature		Date	

### **Guidance Note – Sharing your Health Record**

The Three Chequers Medical Practice takes its responsibility under the Data Protection Act 2018 (incorporating GDPR) very seriously. Please read this information very carefully to understand why, how and when the Practice might wish to share your information with selected other organisations and why we ask for your consent to other organisations sharing your health record with us.



#### **What is your health record?**

Your health record contains all of the information about the care you receive. When you need medical assistance, it is essential to that the Clinician(s) involved in your care can securely access your health record, in order to provide treatment that is tailored to you, based on your medical background. This may include your medical history, medication and allergies.

#### **Why is sharing important?**

By sharing your health record, you receive the best possible care and treatment – wherever and whenever you need it. Choosing not to share your health record could have implications on the quality of care and treatment you receive in the future.

Some examples of how you can benefit from the sharing of your record are:

- Sharing your contact details ensures you received medical appointments without delay
- Sharing your medical history ensures emergency services accurately assess you if needed
- Sharing your medication list will ensure that you receive the most appropriate medication
- Sharing your allergies prevents you from being given something to which you are allergic
- Sharing your test results will prevent you from having to repeat tests more than required

Furthermore, it is important that we can see information that other organisations have added to your health record to ensure that you are receiving the best treatment possible.

#### **Is my health record secure?**

Yes. There are numerous safeguards in place to make sure that only organisation authorised to view your record can do so. You can request information regarding who has accessed your information at any time.

#### **Can I decide who I share my health record with?**

Yes, we will always ask for consent to share your health record unless it is an emergency – if you are unconscious for example.

#### **Can I change my mind?**

Yes – at any time, just let us know.

#### **Can someone consent on my behalf?**

If you do not have capacity to consent, then a Lasting Power of Attorney (LPA) may be able to consent on your behalf. If you do not have an LPA, then a “best interest” decision can be made on your behalf by those caring for you.

#### **What about Parental Responsibility?**

If you have parental responsibility and your child is not able to make an informed decision, then you can make a decision about information sharing on behalf of your child. If your child is deemed “competent” (to make an informed decision) then the decision is theirs.

#### **What is a Summary Care Record?**

A Summary Care Record (SCR) contains basic information about you (contact details, NHS number, medications and allergies etc). GP Practices, Hospitals and emergency services can view this. If you do not want an SCR, then ask the Practice for an “opt-out” form. You can provide consent for an “enhanced” SCR which will include information such as care plans, which will help ensure that you receive the care you require in the future. Further information can be found at:

<https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients>



## 11. Accessing Online Services



**systemonline**  
BOOK REQUEST REGISTER



**Important Information** Please read before completing the form

Patients who wish to, can use the internet to book appointments with a GP, request repeat prescriptions for any medications taken regularly and look at their medical record online. This is in addition to contact through traditional means for all of these services.

It is a patient's responsibility to keep their login details secure. If you suspect that your record has been accessed by someone who does not have permission to do so, then you should change your password immediately. If you are unable to do this, we recommend that you contact the practice so that online access can be revoked until the issue is resolved.

Any information printed from a patient's record, by a patient or their representative, is the responsibility of the patient (or representative) to keep secure. If you are worried about securely storing copies, we recommend that you do not make copies.

In the process of carrying out their normal duties, Practice staff have to input data to your record; this could be attaching a document received or something similar – you may notice administrator or reception staff names alongside some medical information – this is normal and not a cause for concern.

The definition of "Full Medical Record" is all of the information that is held in a patient's record, including; letters documents and free text added by staff, usually the GP. The coded record is all the information that is in coded form, like diagnosis, signs and symptoms – but excludes letters, documents and text. **You must request this separately once your registration is complete.**

Before applying for online access to your record, there are some things to consider. Although the chances of these circumstances are low, you will be asked to confirm that you have understood the following:

### Forgotten History

There may be something that you have forgotten about in your record that you might find upsetting

### Abnormal results or bad news

If you have access to test results or letters, you may see something that you find upsetting to you. This may occur before you have had a chance to speak to a Doctor or while the surgery is closed and unavailable for contacting

### Choosing to share your information with someone

This is your choice to make, and may be very helpful for you – however, it is your responsibility to ensure that your information remains secure.

### Coercion

If you think that you may be pressured into revealing details of your record to someone against your will, it is best that you do not register for online access.

### Misunderstood Information

Your medical record is designed to be interpreted by clinical professionals to ensure you receive the best possible care; therefore some of the information within your medical record may be highly technical, written by specialists and not easily understood. Please contact the Surgery for clarification and explanation of your records.

### Information about someone else

If you spot something in the record that is not about you, or there are other errors, please log out of the system immediately and contact the practice as soon as possible.

More information can be found at: [www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/gp-online-services.aspx](http://www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/gp-online-services.aspx)

Before your request for online access can be processed, we will need to see photographic proof of your identity. In order to ensure that we can complete this request in a timely manner, please ensure that you have brought two forms of Identification (Photo & Address)

I wish to have online access to: (tick all that apply)	
View and book appointments	<input type="checkbox"/>
View and request medication	<input type="checkbox"/>
Access my Summary Care Record	<input type="checkbox"/>
Complete online questionnaires	<input type="checkbox"/>

I wish to access my medical record and understand and agree with the statements below: (tick)	
I have read and understood the "Important Information" on the previous page	<input type="checkbox"/>
I accept that I am responsible for all information I see or download	<input type="checkbox"/>
If I share my information with anyone else, I accept that it is done at my own risk	<input type="checkbox"/>
I will contact the practice immediately if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
I will log out and contact the practice immediately if I see information in my record that is not about me or is inaccurate.	<input type="checkbox"/>

Please note that **both parents** with Parental Responsibility (named on the Birth Certificate) will have to sign this form – if this is not possible, please provide more information below

Full Name			
Signature		Date	
Full Name			
Signature		Date	
Please use this section to add any relevant information			

For Practice use only:

Identity verified by	Self-Vouching <input type="checkbox"/>	Vouching through Information - Check <input type="checkbox"/>	
	Photo ID <input type="checkbox"/>	Proof of Residence <input type="checkbox"/>	Professional Vouching <input type="checkbox"/>
Name of Verifier		Date	
Name of Authoriser		Date	
Photocopied this page <input type="checkbox"/> (name)			
Sent for Scanning <input type="checkbox"/> (name)			

12.	Parent / Guardian's declaration – a person with parental responsibility must complete this section
I have completed this form to the best of my knowledge <input type="checkbox"/>	
First Name	
Surname	
Signature	
Date	

### Registration Checklist

Please ensure you have completed and returned the following sections of the New Patient Registration Pack

Section Number & Title	Patient use Tick to confirm completion	Practice use Tick to confirm receipt and preferences
NHS Registration Form (GMS1) – <b><i>without this we cannot register you</i></b>		
1. Personal Details		
2. Communication Preferences		
3. Background Information		
4. Language and Communication		
5. Carers		Coded? <input type="checkbox"/>
6. Medical History		Medical information coded? <input type="checkbox"/>
7. Your Lifestyle		Smoker / Coded <input type="checkbox"/>
8. Prescriptions		Dispensing Patient? <input type="checkbox"/>
9. Further Details		
10. Sharing Consent		Consent to share (out) <input type="checkbox"/> Consent for organisations to share with us (in) <input type="checkbox"/> Enhanced SCR with additional info? <input type="checkbox"/>
11. Accessing Online Services		
12. Parent / Guardian's declaration		
<b>2 forms of identification provided:</b> (documents of a person with Parental Responsibility are accepted)		
Passport	<input type="checkbox"/>	<input type="checkbox"/>
Driving License (with current address)	<input type="checkbox"/>	<input type="checkbox"/>
Utility Bill (with current address)	<input type="checkbox"/>	<input type="checkbox"/>
Birth Certificate (or court order stating date of birth of child and parental responsibility)	<input type="checkbox"/>	<input type="checkbox"/>