

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”)

1.	Personal Details			
First Name		Sex	Male	Female
Middle Name(s)		Date of Birth		
Surname		Place of Birth		
Address				Postcode

Parental Responsibility – please provide birth certificate or court order to confirm			
Mother's Full Name		Father's Full Name	
Date of Birth		Date of Birth	
Next of Kin?	<input type="checkbox"/>	Next of Kin?	<input type="checkbox"/>
Telephone Number		Telephone Number	

2.	Communication Preferences		
Important Information Please read the Guidance Note “SMS / Email consent” (page 2) before completing the SMS / Email Consent.			
<i>Only enter your contact information below (if you are entering the details of a carer or another individual then you must have their consent to do so).</i>			
Communication Type	Telephone Number	Primary Contact (tick only one)	
Mobile Telephone		<input type="checkbox"/>	
Landline Telephone		<input type="checkbox"/>	
Email Address			

3.	Background Information	
Previous GP Name		
Previous GP Address		
Country of Birth		

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

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"/>	Other (Specify) <input type="checkbox"/>
	Other Christian <input type="checkbox"/>	Hindu <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>	

Living Accommodation	House <input type="checkbox"/>	Bungalow <input type="checkbox"/>
	Mobile Home <input type="checkbox"/>	Bedsit <input type="checkbox"/>
	Lodging <input type="checkbox"/>	Temporary <input type="checkbox"/>
	Ground Floor Flat <input type="checkbox"/>	Upper Floor Flat <input type="checkbox"/>
	Warden attended accommodation <input type="checkbox"/>	Residential Home <input type="checkbox"/>
	Homeless <input type="checkbox"/>	Nursing Home <input type="checkbox"/>

Employment	Student <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>
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4.	Language and Communication				
Language	First Language				
	Second Language(s)				
	Do you have any communication needs?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Hearing Loop <input type="checkbox"/>	Braille <input type="checkbox"/>	Translation services <input type="checkbox"/>		
	Large Print <input type="checkbox"/>	British Sign Language <input type="checkbox"/>	From English – To (specify)		
	“Easy-Read” <input type="checkbox"/>	Makaton Sign Language <input type="checkbox"/>			

Communicating with you

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 write to you or contact you, do you need us to communicate in a particular way? Yes No

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.



By Telephone

I prefer to use the telephone and I use a Hearing Aid.

I prefer to use the telephone and I don't use a Hearing Aid.



By Email

I do not use a Screen Reader

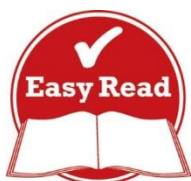
I use a Screen Reader



By Text Message (SMS)

I use a Text-to-speak app

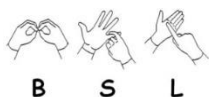
I do not use Text-to-speak app



With Easy Read pictures and words



By using **Large Type**



I need a British Sign Language Interpreter

If you need anything that is not on the list, please tell our receptionist when you come in and we will do our best to meet your needs.

5. Medical History		
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 condition, 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 (brother, mother 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 to 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 also attach a list of your most recent repeat prescription

If you suffer from a Long-term Medical Condition, then you will have to have an annual review of your Medical conditions to check that you are receiving the correct treatment. Tick here to confirm that you understand this <input type="checkbox"/>

Immunisation History – please give details of immunisations that your child has been given.				
Age due	Immunisation	Comments	Batch #	Date given
2 months	Diphtheria / Tetanus / Whooping cough			
	HIB			
	Pneumococcal			
	Rotavirus			
3 months	2 nd dose Diphtheria / Tetanus / Whooping cough			
	HIB			
	Hep B			
	Rotavirus			
4 months	3 rd dose Diphtheria / Tetanus / Whooping cough			
	HIB			
	Hep B			
	Rotavirus			
12-13 months	Measles, Mumps & Rubella (MMR)			
	PCV3			
	HIB			
	Meningitis B			
2 – 4 years	Flu Vaccine			
3 – 5 years	Pre-school Booster Diphtheria / Tetanus / Polio			
	MMR (2 nd dose)			

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

6. Your Lifestyle (continued)					
Smoking – Delete as appropriate					
Do you smoke?	Never		Ex-Smoker		Yes
How many cigarettes do you / did you smoke a day? (delete as required)	1 or less	2 – 9	10 -19	20 - 39	40+
Do you use an e-Cigarette or “Vape”	Never		Ex-user		Yes
Would you like help to quit smoking / “vaping”	Yes		No		For further information, please visit www.nhs.uk/smokefree

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

7. Prescriptions			
Please read the guidance note “Dispensing Medicine” (following page) for more information.			
Dispensing			
Are you eligible to receive prescriptions dispensed by the Practice?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Would you like to receive prescriptions dispensed by the Practice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N / A <input type="checkbox"/>
Electronic Prescribing			
Would you like the Practice to send your prescriptions electronically? If yes, please indicate which Pharmacy you would like us to use.			
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"/>

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:

Pitton	Whaddon	Odstock
The Winterbournes	Alderbury	Nunton
Gomeldon	West Grimstead	Winterslow
Porton	East Grimstead	Coombe Bissett



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.

8.	Further Details
Organ Donation Register	
From Spring 2020, Legislation is changing so that everyone in England is automatically registered as an Organ Donor.	
If you would not like to be an Organ Donor, please tick here <input type="checkbox"/>	

9.	Sharing Consent
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.	
Please take a few moments to read the guidance “Sharing your Health Record” before continuing to provide consent.	
After you have read the guidance note and understood the information, you will be asked to provide consent for sharing your information	

I have read and understood the Guidance entitled “Sharing your Health Record” (previous page) <input type="checkbox"/>	
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Do you consent to your GP Practice sharing your Health Record with other organisations who care for you?	
Yes (this is the recommended option)	<input type="checkbox"/>
No, never (not recommended, please discuss this with a GP before deciding)	<input type="checkbox"/>

Do you consent to your GP practice viewing your Health Record from other organisations that care for you?	
Yes (this is the recommended option)	<input type="checkbox"/>
No (not recommended, please discuss this with a GP before deciding)	<input type="checkbox"/>

Do you consent to having an Enhanced Summary Care Record with additional information?	
Yes (this is the recommended option)	<input type="checkbox"/>
No (not recommended, please discuss this with a GP before deciding)	<input type="checkbox"/>

Full Name			
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 www.nhs.uk/nhsengland/thenhs/records

10. Accessing Online Services



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.

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 your, 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

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 <i>Coded</i> Medical record (definition provided on previous page)	<input type="checkbox"/>
Access my <i>Full</i> Medical record (definition provided on previous page)	<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"/>

Full Name			
Signature		Date	

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)	

11.	Supplementary Information
Please complete the following questionnaire. By providing this information, not only can we improve the care and service you receive from us, it can also improve the service you receive from other agencies including Hospitals and district nursing teams, should you need them.	

With whom do you live?		Do you use a wheelchair?			
I live with (please specify)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		If yes, what type of wheelchair do you use?			
I live alone (friends / family nearby)	<input type="checkbox"/>	Self-propelled wheelchair	<input type="checkbox"/>	Wheelchair pushed by another	<input type="checkbox"/>
I live alone (no friends / family nearby)	<input type="checkbox"/>	Motorised Wheelchair			<input type="checkbox"/>

Relationship Information			
Immediate Family	Please list all living immediate family members (Spouse / cohabiting partner, children / dependants, parents etc) <i>*add extra sheets as required*</i>		
Full Name	Relationship	DOB	Patient of Practice?
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Are you able to walk independently?	
Yes (please specify below) <input type="checkbox"/>	No (please specify below) <input type="checkbox"/>
Walk without difficulty <input type="checkbox"/>	Walk independently with stick <input type="checkbox"/>
	Walk with assistance from 1 person <input type="checkbox"/>
Walk independently with frame <input type="checkbox"/>	Walk with assistance from 2 or more people <input type="checkbox"/>
	Unable to walk at all <input type="checkbox"/>
Walk independently with aids <input type="checkbox"/>	Confined to chair <input type="checkbox"/>
	Bed-ridden <input type="checkbox"/>

Mental Health - In the past 2 weeks, how often have you been bothered by any of the following problems (delete as appropriate)				
Question	Not at all (1)	Several Occasions (2)	More than half of the time (3)	Nearly always (4)
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or oversleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or over-eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you are a failure and have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading or watching the television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people have noticed. Or being fidgety and restless a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thought about hurting yourself deliberately in any way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		
Last name		
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) – <i>without this we cannot register you</i>		
1. Personal Details		
2. Communication Preferences		
3. Background Information		
4. Language and Communication		
5. Medical History		Medical information coded? <input type="checkbox"/>
6. Your Lifestyle		Smoker / Coded <input type="checkbox"/>
7. Prescriptions		Dispensing Patient? <input type="checkbox"/>
8. Sharing Consent		Enhanced SCR <input type="checkbox"/> Consent to share (out) <input type="checkbox"/> Consent for organisations to share with us (in) <input type="checkbox"/>
9. Accessing Online Services		Username and password given <input type="checkbox"/>
10. Further Details		Organ Donor - Opted out? <input type="checkbox"/>
11. Supplementary Information		
12. Parent / Guardian's declaration		
2 forms of identification provided: (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"/>