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
Middle Name(s)			☐ Female
Surname		Date of Birth	
Address			Postcode

Parental Responsibility – 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	
Immediate Family	Please list all living immediate family members living at the same address (siblings, grandparents etc) **add extra sheets as required**		

Full Name	Relationship	D.o.B	Patient of Practice?

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		***Not applicable***
Landline Telephone		
Email Address		
Please specify which method you would prefer to receive communications via:		
Landline ☐	Mobile (call only) ☐	***Please only select one option***
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			☐
I accept that SMS / Email messaging is an additional service and may not be sent on all occasions			☐
I acknowledge that responsibility for attending / cancelling my appointments rests solely with me			☐
I take responsibility to ensure that my contact information is kept up to date with the Practice			☐
I give my permission for Answerphone Messages to be left on my Mobile / Landline telephone			☐
Full Name		Date	
Signature		Tick if you signed on patient's behalf	☐

3.	**Background Information**
Previous GP Name	
Previous GP address:	
Country of Birth	

Ethnic Origin	White (British) ☐	Chinese ☐	Black (African) ☐	Black (Caribbean) ☐
	White (Other) ☐	Indian ☐	Bangladeshi ☐	Pakistani ☐
	Arabic ☐	Prefer not to say ☐	Other (specify)	

Religion	C of E ☐	Buddhist ☐	Sikh ☐	Atheist ☐
	Catholic ☐	Muslim ☐	Jewish ☐	Hindu ☐
	Jehovah's Witness ☐	Other Christian ☐	Other (please specify)	

Living Accommodation	House ☐	Bungalow ☐	Ground Floor Flat ☐	
	Mobile Home ☐	Bedsit ☐	Upper Floor Flat ☐	
	Lodging ☐	Temporary ☐	Residential Home ☐	
	Homeless ☐	Nursing Home ☐	Warden-attended ☐	
With whom do you live?	Family ☐	Other Relatives ☐	Carer ☐	Guardian ☐

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

Employment	Student ☐	Other (specify)

4.	**Language & Communication**			
Language	First Language			
	Second Language(s)			
	Do you have any communication needs?		Yes ☐	No ☐
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 we 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.				
Communication	Hearing Loop ☐	Large Print ☐	Makaton Sign Language ☐	
	“Easy-Read” ☐	Braille ☐	British Sign Language ☐	
	Translation ☐	From English to:		

5.	**Carers**		
Please read the guidance note “Carers” (page 4) before completing this section:			
Are you a Carer?		Yes ☐	No ☐
Name of the person for whom you care			
Relationship to you		Spouse ☐	Neighbour ☐
		Friend ☐	Other ☐
Are they a registered patient of the Three Chequers Medical Practice?		Yes ☐	No ☐

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.

6.	**Medical History**				
Have you ever suffered from any of the following conditions?					
Asthma	☐	Cancer (information below)	☐	COPD	☐
Depression	☐	Diabetes	☐	Epilepsy	☐
Heart Disease	☐	Heart Failure	☐	High-Blood Pressure	☐
Kidney Disease	☐	Stroke	☐	Underactive Thyroid	☐
Any other conditions, operations or hospital admissions or furhter 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	☐	Cancer (information below)	☐	COPD	☐
Depression	☐	Diabetes	☐	Epilepsy	☐
Heart Disease	☐	Heart Failure	☐	High-Blood Pressure	☐
Kidney Disease	☐	Stroke	☐	Underactive Thyroid	☐
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	Diptheria / Tetanus / Polio / Whooping Cough / HiB/ Hep B			
	Rotavirus			
	Meningitis B			
3 months	Diptheria / Tetanus / Polio / Whooping Cough / HiB/ Hep B			
	2nd Dose Diptheria / Tetanus / Whooping Cough			
	Rotavirus			
	Pneumococcal			
4 months	Diptheria / 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)			
	Diptheria / Tetanus / Polio / Whooping Cough			
Teenage Vaccines	HPV (2 doses, 6 to 24 months apart) – Females only			
	Diptheria / Tetanus / Polio			
	Meningitis ACWY			

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

7.	Lifestyle				
Smoking					
Do you Smoke?	Never ☐		Ex-Smoker ☐		Yes ☐
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 ☐		Ex-Smoker ☐		Yes ☐
Would you like help giving up smoking?			No ☐		Yes ☐

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

8.	Prescriptions
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	Firsdown	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 ☐	No ☐
If yes, would you like the Practice to dispense your prescriptions	Yes ☐	No ☐
If yes, which surgery would you like to collect your medicine from?	Porton & Old Sarum Surgery ☐	Winterslow Surgery ☐
Electrionic Prescribing		
If you are not eligible for Practice Dispensing, would you like the Practice to send your prescriptions electronically?	Yes ☐	No ☐
Pharmacy Name & Location		
I understand that I will have to undertake annual reviews of all Medicine I take ☐		

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

10.	**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 (following page) entitled "Sharing your Health Record" ☐	
Do you consent to your GP Practice sharing your Health Record with other organisations who care for you? Yes (this is the recommended option) ☐ No (not recommended, please discuss this with a GP before deciding) ☐	
Do you consent to your GP practice viewing your Health Record from other organisations that care for you? Yes (this is the recommended option) ☐ No (not recommended, please discuss this with a GP before deciding) ☐	
Do you consent to having and Enhanced Summary Care Record (SCR) with additional information? Yes (this is the recommended option) ☐ No (not recommended, please discuss this with a GP before deciding) ☐	
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.	**Parent / Guardian’s declaration** – a person with parental responsibility must complete this section
I have completed this form to the best of my knowledge	☐
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) – ***without this we cannot register you***		
1. Personal Details		
2. Communication Preferences		
3. Background Information		
4. Language and Communication		
5. Carers		Coded? ☐
6. Medical History		Medical information coded? ☐
7. Your Lifestyle		Smoker / Coded ☐
8. Prescriptions		Dispensing Patient? ☐
9. Further Details		
10. Sharing Consent		Consent to share (out) ☐ Consent for organisations to share with us (in) ☐ Enhanced SCR with additional info? ☐
11. Parent / Guardian's declaration		
2 forms of identification provided: (documents of a person with Parental Responsibility are accepted)		
Passport	☐	☐
Driving License (with current address)	☐	☐
Utility Bill (with current address)	☐	☐
Birth Certificate (or court order stating date of birth of child and parental responsibility)	☐	☐