The Rushey Green
Group Practice
The Primary Care Centre, Hawstead Road, London SE6 4JH
Email: lewccg.g85633-general@nhs.net Tel: 020 7138 7150 Fax: 020 8690 7185
DR JUDY CHEN MRS GILL SULTAN DR ALBERTO FEBLES

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 and appliances*

**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_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

Updated 27.8.2016

NHS Family doctor services registration

GMS1

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:

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

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

NEW PATIENT REGISTRATION FORM

Please return fully completed forms to the Practice *in person*
Monday – Friday between 8.30am – 6.30pm. Please note during busy times you may have to wait, as the telephone's take priority. Thank you.

Patient Details:

Title: Mr / Mrs / Miss / Ms **Date of Birth:**……/……../……..

Gender: Male / Female **Martial Status: ……..……**

Surname:…… **First Name:**……

Have you lived in UK for more than 5 years: Yes ☐ **No** ☐

If the answer to the above question is No, which year did you enter the UK? …….

If you have not lived in the UK for more than 5 years , which country/countries did you

live in before coming to the UK? ……

Have you travelled abroad in the last 6 months? Yes ☐ **No** ☐

If the answer to the above question is Yes, which country/countries did you visit?

……

Home Address including Post Code: ……..

……

Mobile Number: ……..**Home Number:** ……

Work Number: ……**Email Address:**…….....

Main language spoken:……**Interpreter needed:** ☐ **Yes** ☐ **No**

Previous or current contact with Social Services: ☐ **Yes** ☐ **No**

Next of Kin (emergency contact):

Name: ……**Relationship:** .....

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Telephone Number(s): ……

Text Message Appointment Reminders:

Do you want to use the SMS text message service? ☐ **Yes** ☐ **No**

SMS Text Messaging: You can take advantage of our SMS messaging service, by authorising us to use your mobile telephone number. We can send you details direct to your mobile phone about your forthcoming appointments, time, date and who your appointment is with.

Your Medical Record:

Have you been a patient with us before? Yes ☐ No ☐

Lifestyle:

Height: ……. Weight: …….

Any known allergies: ……..

Smoking Information:

( ) I have never smoked
( ) I currently smoke …… cigarettes
( ) I am an ex smoker

I currently smoke and would like to give up smoking Yes/No

Alcohol:

Units per week ……of alcohol

Smear Test (females only):

Date of last test: …….. Result of last test: ……

Ethnic Monitoring

Please tick which ethnic group best describes your background?

White	**Asian or Asian British**	**Mixed**	**Black**
☐ British	☐ Indian	☐ Black Caribbean & White	☐ Caribbean
☐ Irish	☐ Pakistani	☐ Black African & White	☐ African
☐ Other White	☐ Other Asian	☐ Other Mixed	☐ Other Black

Carer Information

A Carer is someone who looks after a family member, a partner or friend in need of help because they are mentally or physically ill, frail or disabled.

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Are you a Carer? ☐ Yes ☐ No

If yes, please state who you care for:

Name:……Relationship:……

Is someone a Carer for you? Yes/No

If yes, please state Carer's name:……..DoB:…./…./

Address:…….

Patient to sign below to confirm receipt of Rushey Green Group Practice Patient Agreement.

Signed……

Date……

For Office Use only

Date Accepted:	
Name of Receptionist who checked Form:	
Missing/Vulnerable Families Register checked	
Proof of Residency seen (specify) i.e. bank statement, council tax bill, tenancy agreement etc.	
ID copy taken for Online access:	Yes or No
New Patient Check Appointment Date & Time:	Date: Time:
Named Accountable GP, patient informed:	Dr Chen or Dr Febles
Details entered on EMIS:	
EMIS Access Pin Emailed to patient:	Yes or No

Rushey Green Group Practice Patient Agreement

Updated 27.8.2016

Please understand that by completing and signing this form you agree to the following:

a) That you have completed the registration questionnaire to the best of your knowledge.

b) To keep your appointments and if you are unable to do so you will inform the practice as soon as possible. (We will remind you of your appointments by text if you give us a mobile number).

c) That you undergo a new patient health check if over 40 years old or have not lived in the UK for more than 5 years to validate your registration

d) To keep us updated of any change of address or telephone number

e) To behave towards the Practice staff as you would expect us to behave towards you, not using threatening, aggressive or bullying behaviour towards our staff / other patients.

f) To not deface or cause damage to any part of the building or its grounds.

Signature of Patient:..... **Date:** ..... / ..... / .....

<u>What Happens Next?</u>

- Please take these completed forms to the Practice anytime, however it may be better not to come during our peak periods (8am – 11am or 1pm - 2pm) together with your proof your address and photo ID, and you can expect to be registered **within 5 working days**.

- You will be booked a New Patient Health Check if over 40 years old or have not lived in UK for more than 5 years to validate your registration.

- If we are unable to register you, we will notify you of the reasons in writing.

- Your NHS medical card will be sent to you from NHS England within 12 weeks of registration if you are new to the area.

- Your named GP will be Dr…….…….. but you are entitled to see any Doctor at the Practice.

- You are encouraged to ask to see the same Doctor whenever you book a routine appointment. For an urgent appointment you will be allocated any of the doctors available for the session.

THANK YOU FOR COMPLETING THIS FORM

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