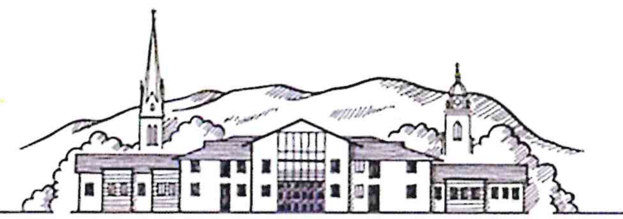

Upton Surgery, Tunnel Hill, Upton-upon-Severn, Worcestershire, WR8 0QL.
Tel: 01684 592696   Web: www.uptondoctors.co.uk

Our ref: NP/PI/3

Welcome

Welcome to Upton and to our Practice. We are happy to accept you on our list if you are within our catchment area (a map can be found on our website www.uptondoctors under the new patient section.) Along with this letter you will receive a Practice Profile which will tell you most of what you will want to know.

Proof of Identity

Fraud is becoming increasingly common in the NHS where patients use false identities or provide fake documents when they register with a GP. Therefore, when registering, the Practice will require two separate proof of identity documents:

One form of photo ID, e.g. passport, driving licence, bus pass

One original document to confirm your residential address, e.g. recent utility bill

Invitation to attend for a general medical check

Under the Government's arrangements for General Practice you are encouraged to attend for a general medical check with one of our nurses or your new doctor if you are on regular medication. As part of this check we would like you to fill in a medical and social history form as this will be helpful to us before your medical records reach us.

We hope you will make an appointment for this check-up within 2 months of your registering with us.

Children under 5 years of age do not need to attend for a new patient check. Parents will be contacted by a Health Visitor, who will discuss child health development and the availability of local services.

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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: .... Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **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

Signature confirming my consent to join the NHS Organ Donor Register Date ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register Date ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name .... Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date ____/____/____

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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:
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.	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

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 costs from your home country.

Dr Barrell & Partners
New Patient Questionnaire Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family.)

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

Full Name(including title):					***Telephone Number:**		
*** Your preferred method of contact from the Surgery (when necessary):**					***Work Number**		
New Address and Postcode					***Mobile Number:** *We do correspond via SMS text messaging, please let us know if you wish to opt out of this service.*		
					***E-mail Address:**		
					Next of Kin: Mr/Mrs/Miss/Ms:		
Date of Birth:		**Previous / or Mother's surname if different:**			**Relationship of Next of Kin:**		
Marital Status:		**Gender:**	**Male:**	**Female:**	**Next of Kin contact number:**		
Occupation:					**Your Town and Country of Birth:**		
Names & Ages of Children							
					NHS Number (if known)		
Previous Address and Postcode					**Previous Postcode:**		
					Previous Doctor Telephone No.		
Previous Doctor Name & Address:					**Previous data released?**	**Yes**	**No**
					If applicable, date you first came to live in Britain:		
If returning from Armed Forces:		**Your Service or Personnel Number**			**Your Enlistment Date**		
Your height:	**Feet / inches**		**cm**	**Your weight:**	**Stones / lbs.**	**kg**	
Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**		**Buddhist**	**Hindu**	**Muslim**

	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	No. times per week		Type(s) of exercise:		

Your Medical Background:

What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	

Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)				
	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer
	Breast Cancer	High Blood Pressure	Asthma	Stroke
	Thyroid Disorder	Any other important Family Illness?		

What immunisations have you had? (please tick all that apply with dates given)						
	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**	
	Signed:	**Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	*If "Yes", can you please bring a written copy of it to your New Patient Consultation*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney for your Health and Welfare)?	Yes / No	If "Yes", please state their name / address / phone number:
Have you had or have you got a named Social Worker or have or have had help from the Early Help Hub	Yes/No	If "Yes", please give details
Are you a military veteran?	Yes/No	If "yes", please give details
Are you happy to have this recorded on your medical record	Yes/No	What was your service number?

Women only:

When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide:

Patient Participation Group and Virtual Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group and/or Virtual Patient Participation Group (Please tick the "Yes" Box)	Yes

Patient Signature:		Signature on behalf of Patient:	

Your physical examination will include having your height, weight and blood pressure taken, and a urine test.

Specimen containers are available from reception and it would be helpful if you would bring a specimen with you when you attend for your new patient check.

The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.uptondoctors.co.uk

Upton Surgery
Alcohol Users Disorders Identification Test (AUDIT)

Patient Name: ____________________ Date of Birth: ______________ Date of Test: __________

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor or health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence.