

## Patient's details

Please complete in BLOCK CAPITALS and tick  as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms				Surname			
Date of birth				First names			
NHS No.				Previous surname/s			
<input type="checkbox"/> Male <input type="checkbox"/> 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			
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## If you are returning from the Armed Forces

Address before enlisting

.....

Service or Personnel number				Enlistment date			
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## 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### 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](http://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: .....

HA use only   Patient registered for    GMS    CHS    Dispensing    Rural Practice

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.*

Practice Stamp

Authorised Signature

Name Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SUPPLEMENTARY QUESTIONS**

**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.**

<b>Signed:</b>		<b>Date:</b>	DD MM YY
<b>Print name:</b>		<b>Relationship to patient:</b>	
<b>On behalf of:</b>			

**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: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
 <p><i>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.</i></p>	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

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.

# **Balmoral Surgery** **New Patient Pack**



**Please ensure that you complete and return the registration form and the health questionnaire enclosed in this pack.**

***Further information about the practice can be found on our website:***

***[www.balmoralsurgery.com](http://www.balmoralsurgery.com)***

# Balmoral Surgery

## New Patient Health Questionnaire



Please take time to fill out this important form as it will hopefully improve the care we provide to you. Please return it to Reception .

<b>Title:</b>	<b>Date of Birth:</b>
<b>Surname:</b>	<b>Forenames:</b>
<b>Previous Name (if applicable):</b>	<b>NHS number:</b>
<b>Telephone Home:</b>	<b>Mobile:</b>
<b>E-mail Address:</b>	<b>Occupation:</b>
<b>Next of Kin (and their relationship to you):</b>	
<b>Ethnic Origin:</b>	<b>First Language Spoken:</b>

<b>Previous Doctor:</b>
<b>Address of Previous GP:</b>

<b>Have you ever lived abroad:</b> Yes/No
<b>If yes, please give details and dates:</b>
<b>Are you a Carer:</b> Yes/No
(Delete as applicable)

<b><u>Smoking Status:-</u></b>		
Current Smoker <input type="checkbox"/>	Non-smoker <input type="checkbox"/>	Ex-smoker <input type="checkbox"/>
<b>If you are a current smoker, how many do you smoke a day, and in what form?</b>		
Cigarettes <input type="checkbox"/>	Pipe <input type="checkbox"/>	Cigars <input type="checkbox"/>
<b>If you are an ex-smoker, when did you last smoke?</b>		

**Alcohol Consumption**

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    9-10    10+  
                   

How often do you have 6 or more standard drinks on one occasion?

Never    Monthly or less    2-4 times per month    2-3 times per week    4+ times per week  
                                                               

**Height:**

**Weight:**

**Waist Measurement:**

**Are you under the care of a hospital specialist? Yes/No**

**If yes, please give brief details: -**

**When were you last immunised against Tetanus?**

**(For Women Only)**

**(a) When did you last have a cervical smear?**

**(b) Are you fitted with a coil? Yes/No**

**Are you taking any medication? Yes/No**

**If yes, please give details;**

Name of Medicine	Dose/Strength	Times Daily

**Are there any medicines or drugs that have upset you in any way: Yes/No.**

**If Yes, how?**

Name of medicine	What was the problem or upset

**Any other allergies?**

**Health History**

Please list any serious illnesses, accident, operations, and disabilities.

Women: Please include problems in pregnancy or at delivery


**Family History**

Relationship (e.g.: mother)	Date of Birth (Year)	State <b>present health</b> , any serious illnesses especially angina, heart attack, stroke, high blood pressure or asthma	Year & cause of death

**Have any Uncles, Aunts, Nephews, Nieces or Grandparents suffered from any serious or family illnesses?**

**Do they have diabetes, heart disease, obesity, high blood pressure or glaucoma? Yes/No**

**Do you have any children? (Under 18)**

**Names**

**Date of Birth**

1.....

2.....

3.....

4.....

5.....



Your emergency care summary

CONFIDENTIAL

## OPT-OUT FORM

### Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

**A. Please complete in BLOCK CAPITALS**

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS number (if known) ..... Signature .....

**B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B**

Your name ..... Your signature .....

Relationship to patient ..... Date .....

**What does it mean if I DO NOT have a Summary Care Record?**

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

**FOR NHS USE ONLY**

Actioned by practice yes/no ..... Date .....

Ref: 4705

# Care.Data

Confidential information from your medical records can be used by the NHS to improve the services offered so that the best possible care can be provided for everyone. This information, along with your postcode and NHS number but not your name, is sent to a secure system where it can be linked with other health information.

This allows those planning NHS services or carrying our medical research to use information from different parts of the NHS in a way which does not identify you.

You have a choice.

If you decide that you do not want your data to be used in this way, and have made sure you fully understand this project before reaching your decision please complete below:

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## REQUEST FOR MY CLINICAL INFORMATION TO BE WITHHELD FROM CARE.DATA

If you **DO NOT** want your personal confidential data to be included in the Care.Data programme please fill out the form and hand it to the receptionist at Balmoral Surgery.

Please complete in block capitals:

Title ..... Surname/Family Name.....

Forename(s) .....

Address .....

Postcode ..... Date of Birth .....

Signature .....

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If you are filling out this form on behalf of another person or child please complete their details in section A and yours in section B.

Your Name ..... Your signature .....

Your relationship to patient ..... Date .....

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Please indicate which parts of the programme you wish to withhold your information from by ticking appropriately:

**#9Nu0 Dissent from secondary use of GP patient identifiable data** (prevent personal confidential data leaving the Practice.)

**#9Nu4 Dissent from disclosure of personal confidential data by Health and Social Care Information Centre** (prevent personal confidential data leaving HSCIC.)



## **Information to Keep -**

### **Support advice for Carers**

As a carer you may be entitled to extra support at home in order to help you carry out your important role. Balmoral Surgery suggests you contact one of the following, to find out more about this:-

- Your employer if you are in work
- The Benefits Agency
- Social Services
- Citizens Advice Bureau

### **Text Messaging Reminder Service**

Balmoral Surgery uses a text messaging service to remind patients of the date and time of their appointment. The message will not contain any confidential information about your care and receiving the text message is free. If you have provided the surgery with a mobile number, you will be included in this service. If you do not want to be included please speak to a receptionist on 01304 373444.

You are responsible for informing us of any changes to your mobile telephone number.

### **Electronic Prescription Service**

Balmoral Surgery offer electronic transfer of prescriptions direct to the patient's choice of Pharmacy. This means there is no need for a paper prescription and it will cut down the interactions the patient needs to make to order and collect their prescription and then their medication. Once ordered, the prescription will transfer electronically directly to the Pharmacy meaning the patient does not need to call at the Surgery to collect a paper prescription. Patients who are interested in this service should contact reception for more details and to nominate their chosen Pharmacy.

### **Online Repeat Prescriptions & Appointments**

Patients can make appointments online, and order their repeat medication online. Please enquire at reception for more information and to register for this service. After registration appointments can be made, and prescriptions ordered by going to [www.myvisiononline.co.uk](http://www.myvisiononline.co.uk)

### **Surgery Closures**

Please note that Balmoral Surgery is closed from 1pm on some days once a month to allow the doctors and staff to have protected learning time. These sessions are arranged by the South Kent Coast Clinical Commissioning Group and offer the opportunity for the Surgery teams in our locality to get together for training purposes.

These sessions are usually on a Thursday afternoon once a month and at present are scheduled to take place as follows: 17.10.13, 6.11.13, 16.1.14, 20.2.14 & 20.3.14.

During these sessions, access to medical services can be made by dialling 111 for the NHS 111 service.

### **Are you thinking about giving up smoking?**

The practice offers a stop smoking clinic; please speak to a receptionist for further details.