Dr Perry & Partners
Brant Road Surgery & Springcliffe Surgery
Patient Registration Form
(16 years and over)

In order to assist the practice with your care whilst we await your complete medical records from your previous practice – please complete this confidential form:

Surname…… Title……. Date of Birth……..

First Name(s)…… Place of Birth……..

Previous surname…….. Occupation……..

NHS Number: …… First Language spoken……..

Full address……

…… Post code……

Email…….. (You will receive a verification email which you should respond to)

Telephone Number…….. Mobile……

We send appointment reminders and contact requests by text message.
No confidential information, such as test results, will be sent this way. If you agree to us using this method of contact, please indicate here: YES/NO

Your previous address

……

……

Previous GP and Medical Practice……

If recently arrived in the UK please complete the section on page 2 before completing all other details (please refer to Receptionist if you have any difficulty in completing this)

Ethnicity……

Next of Kin…… Relationship……

Next of Kin's address……

…… Telephone No ……

If you have recently left the Armed Forces:

Date of Enlistment:…… Date of Discharge:……

Service/Personnel No:……

IF YOU REQUIRE A NEW PATIENT CHECK, PLEASE BOOK IN AT RECEPTION *(XaCGg)*

IF NEW ARRIVAL INTO THE UK

Date of Arrival…… (please provide your exact date of arrival DD/MM/YYYY)

Eligibility to NHS Medical Services determined by reason of (PLEASE TICK)

☐ I am living in the UK lawfully and on a settled bases and have been resident/intend to reside for more than 6 months AND CAN PROVIDE EVIDENCE TO SUPPORT THIS.

☐ I am a student and can provide evidence of this (if so is the course government funded? Yes/No)

If no, how long is the duration of the course? ……

☐ I am an EEA National coming to UK to Work/Study. **I have a valid E128 Form/EHIC**

☐ I am an asylum seeker

PLEASE ENSURE YOU COMPLETE THE DECLARATION ON THE REVERSE OF THE GMS1 (PURPLE) FORM

Name……

Signed……..

Date…….

Do you have a carer? Yes/No Are you a carer? Yes/No

Their relationship to you…….. Carers contact number……..

Carers address……..

……..

Please advise of any disabilities you have……

……

YOUR FAMILY HISTORY – Have any close relatives any history of:

	Please circle whichever applies
Angina/heart attack **Under 60**	Father Mother Brother Sister Other member……No FH
Angina/heart attack **Over 60**	Father Mother Brother Sister Other member……No FH
Diabetes	Father Mother Brother Sister Other member……No FH
Cancer	Father Mother Brother Sister Other member……No FH
Please state type of cancer:	
High Blood pressure	Father Mother Brother Sister Other member……No FH
Stroke	Father Mother Brother Sister Other member……No FH

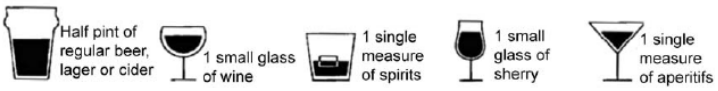
SMOKING STATUS

(We strongly recommend that you do not smoke and offer appointments and leaflets to assist you to stop smoking).

Never smoked	
I used to smoke but do not smoke now	
I do smoke, please enter quantity per day smoked…….	
I do smoke and would like help from the practice to give up	

ALCOHOL

This is one unit of alcohol…



…and each of these is more than one unit

FAST	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Weekly (3) or Daily (4). Stop here if the answer is Never (0), Less than monthly (1) or Monthly (2).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

EXERCISE– How much exercise do you take?

Exercise impossible:	Little or none
Light (e.g. walking to shop, gardening, golf)	Moderate (e.g. 20 minutes brisk walk 3 times per week)
Heavy (20 mins, 3 times a week with increased pulse	Competitive athletics (or similar)

Current medication – please indicate name and dosage of drug and medical condition/reason for each drug.

Please note: An appointment with a Doctor will be required before we are able to issue any medication.

Allergies:

Past medical history – Please write here details of anything you would like your doctor to know about your past medical history (in particular include if you have had angina, stroke, heart attack, high blood pressure, asthma, diabetes, COPD (chest condition requiring inhalers), or any operations). Please indicate the above medications you are taking for these conditions.

Year	**Event**

Do you have Diabetes? YES/NO

Do you use an inhaler for a chest complaint? YES/NO

Date of last influenza vaccination (annual vaccination) ……..

Have you had a pneumonia vaccination? YES/NO Date……..……

Have you had a tetanus injection in the last 10 years? YES/NO Date……..……

Have you had 5 or more tetanus injections in your life? YES/NO

Women only

Have you had a cervical smear in the last 5 years? YES/NO

Date of last smear (if known) ……..……..

Brant Road Surgery
291 Brant Road
Lincoln
LN5 9AB
01522 724411

Springcliffe Surgery
42 St Catherines
Lincoln
LN5 8LZ
01522 524725

Application for password to use Systm On-Line

Name ……..

Address……

……..

Date of Birth ……

(Please note we are unable to issue passwords to patients below the age of 16)

Date of application ……..

Please issue a password to enable me to access the Systm On-Line website. I am aware of the following conditions:

- I accept all responsibility for the password and any access to the system using the password.
- I am aware that if I divulge the password to other parties, they will be able to access information about me.

The Practice reserves the right to revoke access immediately (without notification) if there is abuse of the system such as:

* Booking appointments and not attending.
* Repeatedly booking and then cancelling appointments.
* Repeatedly requesting prescriptions that I do not need.

Signed……

For Surgery use only:

Identification Produced ……

Member of staff……

Password Issued (date) ……

Dr Perry & Partners

Electronic Prescription Service (EPS)

Nominated Pharmacy Form

Patient Name & Address	
Telephone Number:	
Date of Birth:	
NHS Number:	

I am the patient named above.

(Please note: if you had a nominated pharmacy with your previous practice, this will be cancelled when your registration paperwork is processed. You will need to select a new pharmacy as detailed below.)

I have read the Electronic Prescription Service leaflet and would like to nominate the following pharmacy (please tick ONE only):

Asda	
Boots Chemist (please detail which	
Lincoln Co-Op (please detail which	
Medicines Plus	
Sainsburys	
Other – please provide details	

Signed: _____ Date: _____

Information and Communication Support

- Do you have any information or communication support needs relating to a disability, impairment or sensory loss? (please tick as applicable)

Yes		No	

Office use only: (Y4523)

- If you have answered 'yes', please explain how our service can best meet your support needs:-

For example: Do you need a British Sign Language interpreter?
Do you need an advocate?

- If you have answered 'yes', do you require a specific contact method due to your disability, impairment or sensory loss and/or do you require information in a specific format (whenever possible)?

For example: Do you require contact by telephone?
Do you require contact via a carer?
Do you require letters in Easyread or larger font size?

Thank you for taking the time to complete this form. An alert will now be placed on your record to indicate that you have information and/or communication support needs.

Patient Name…….

Date of Birth……

Signature…….

Office use only: Form entered by:_____ Date:_____

Dr Perry & Partners

PATIENT INFORMATION SHARING AND CONSENT FORM

Name of Patient: _____ **Date of Birth:** _____

Address: _____

Postcode: _____ **NHS No:** _____

All information you give to a member of the practice team is safeguarded by the Data Protection Act and the NHS Care Record Guarantee. At all times, everyone working for the NHS, has a legal duty to keep information about you confidential. However, information is sometimes shared where it is absolutely necessary to support your care or help improve the service provided by the NHS. **You have a choice about whether your information is shared and for what purpose.** Please use the boxes below to tell us what your choices are.

Summary Care Record (SCR) (consent – XaXbY / dissent – XaXj6)		
A Summary Care Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.		
Do you want a Summary Care Record? *(If you select "Yes" a record will be created for you, but you but can opt-out at any time)*	***Yes***	***No***
Enriched Summary Care Record (consent – XaXbZ / dissent – XaXj6)		
Additional information can be added to your SCR by your GP practice and is a summary of information about your medical history. It can include the following: your long-term health conditions; your relevant medical history, your immunisations and your health care needs and personal preferences, including end of life wishes.		
Do you want an Enriched Summary Care Record? *(If you select "Yes" a record will be created for you, but you but can opt-out at any*	***Yes***	***No***
Detailed Records Sharing (EDSM)		
This GP practice is able to share your electronic **GP record** with healthcare professionals caring for you elsewhere (e.g. in community, hospital or urgent care services). This may help in your care and may save you from		
Do you consent to the information that is recorded by this GP Practice being made available to other NHS care services that	***Yes***	***No***
Implied consent is in place for this GP Practice to view information about you that has been recorded at other care ser-	***Yes***	***No***

Patient Signature: _____ **Date:** _____

If you have signed on behalf of the above person, please state:

Name: _____ Relationship: _____

Address: _____ Postcode: _____