THIS FORM MUST BE RETURNED TO THE SURGERY BY HAND SO WE CAN BOOK YOUR NEW PATIENT CHECK.

NEW PATIENT REGISTRATION FORM

WELCOME TO LEN VALLEY PRACTICE

ONCE ALL SECTIONS OF THIS QUESTIONNAIRE ARE COMPLETED AND RETURNED YOUR REGISTRATION WILL BE PROCESSED

Please write in **BLACK INK.**

v 31/5/2018

The information that you provide will be treated in the strictest confidence. If you are completing this form for a person who is under 16 years of age, please be aware that once they reach their 16th birthday they will receive a letter from the practice asking them to complete another form themselves.

PERSONAL DETAILS					
Title	Mr/Mrs/Ms/Miss Other:	**First Name**		**Surname**	
Previous Name		**Address**			
Date of Birth					
NHS Number					
Home Tel No		**Postcode**		Office use only: **DISP:** Yes ☐ No ☐ **Miles:**	
Mobile Tel No **Only fill in if you give permission for us to contact you using your mobile number**		**Email** **Only fill in if you give permission for us to contact you using your email address**			
Work Tel No		**Sex**	Male ☐ Female ☐		
Town of Birth		**Country of Birth**			

EMERGENCY CONTACT DETAILS This will be the person that the surgery contacts in case of Emergency					
Title	Mr/Mrs/Ms/Miss Other:	**First Name**		**Surname**	
Home Tel No					
Mobile Tel No					
Work Tel No					
Relationship to you					
Is this person also your Next of Kin?			Yes ☐ No ☐		
Can this person discuss your medical records? This person will have access to your appointments, results and other confidential information. You will contact the Practice if any of these details change.			Yes ☐ No ☐		
Signature:		**Date:**			

CARER DETAILS (You are a carer if you spend a significant portion of your time providing paid/unpaid support to another person)	
Are you a carer? (If "Yes" please tell us who for (Name) and their relationship to you)	Yes ☐ No ☐
Do you have a carer? (If "Yes" please tell us their name and their relationship to you)	Yes ☐ No ☐

Office Use Only (RECEP)		**ADULT / CHILD**				**Initial box when ALL RECEP tasks completed**	
Named Accountable GP given to patient	Initials of GP:	***Residential Home Entered***		Next of Kin signature checked		Sections checked (Y or N ticked)	
Office Use Only (ADMIN)						**Initial box when ALL ADMIN tasks completed**	
'New Patient Form Codes' Template completed in EMIS		AIS CODES in EMIS		ALLERGY CODES in EMIS		SMS/Email ALERTs in EMIS	
Organ/Blood Donor Record entered (Exeter)		**FEMALES: (24-65Y)** Cytology checked (Exeter)					

PREVIOUS DETAILS	
Previous Home Address	
Previous GP (Name and Address)	

If you are from ABROAD	
First UK address where registered with GP	
If previously resident in the UK, date of leaving	
Date you first came to live in the UK	

ARMED FORCES	
If you have served or are serving in the ARMED FORCES please answer the following questions:	
Service or Personnel Number	
Enlistment Date	
Address before enlisting	

NHS ORGAN DONOR REGISTRATION

I would like to join the NHS Organ Donor Register as someone whose organs 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

For more information visit: www.uktransplant.org.uk or call (0300) 123 23 23

Please sign and date to confirm consent:

Signature		**Date**	

NHS BLOOD DONOR REGISTRATION

PLEASE READ BEFORE SIGNING:

You must be at least 17 years old to donate blood.

My preferred address for donation is: ☐ As above ☐ Somewhere else e.g. your place of work *(please specify below):*

I would like to, and am eligible to, join the NHS Blood Donor Register as someone who may be contacted, and would be prepared to donate blood.

Tick if you have given blood in the last 3 years ☐

For more information ask for the leaflet on joining the NHS Blood Donor Register

Please sign and date to confirm that you are eligible to donate, and to give your consent:

Signature		**Date**	

SMOKING STATUS

Do you smoke?

Yes ☐ How many cigarettes a day?_____

Would you like help to stop smoking?

Yes ☐ No ☐

No ☐ Have you ever smoked? Yes ☐ No ☐

If Yes, please give the **date you stopped**:

If **Yes**: Support will be provided by Kent Community Health NHS Trust Stop Smoking Services, who will be in contact with you shortly. We are required to send them some basic information from your record, e.g. name, address, DOB

I consent to the practice sharing my details as above _____ (Signature)*

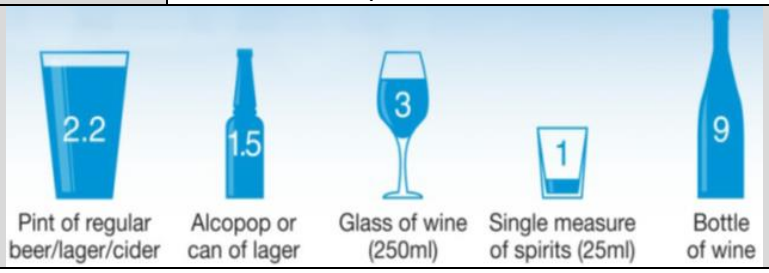
The Stop Smoking Service can leave a message for me _____ (Signature)*

*** Please ensure you have included your mobile telephone number and/or email address on this form.**

ALCOHOL CONSUMPTION

Alcohol can affect your health and certain medications.
Use the guide below to assess how many units you drink in a week.

Do you drink alcohol? Yes ☐ - Units per week: No ☐



ALLERGIES to MEDICATION

Do you have an adverse reaction to any medication?	Yes ☐ No ☐	**If Yes, please list here:**

DIABETIC PATIENTS

Are you Diabetic?	Yes ☐ No ☐	***This information will help us to direct you to one of our diabetic specialists for your New Patient Check.***

COMMUNICATION PREFERENCE (AIS)

If you require additional assistance when communicating with the practice, please indicate it below by ticking the relevant box. If not, please tick 'No additional assistance required'

☐ No additional assistance required, thank you.

SIGHT		SOUND	
Large Print	☐	British Sign Language	☐
Braille (state grade)	☐	Audio Cassette Tape	☐
Other (please state)	☐	Other (please state)	☐

Patient Access – Online Services

We offer online access for you to book/cancel appointments, view some of your medical information and order repeat medication.
You need to be registered for this service in order to use it.
You can *only* apply for yourself and must be aged 16 or over.
Photo ID is required to register for this service.

Please ask at reception for further information.

Data Sharing

We take the confidentiality of your personal and medical information very seriously.

When appropriate, Len Valley Practice will share pertinent details of your clinical record between the various care professionals who are or will be involved in your clinical care (your GP, local hospitals, district nurses, out of hours services, health visitors, etc). This data is only used for your direct medical care.

There are other occasions when we have requests to share your data. You have the option to opt out of these.
On the next pages these options are explained and you must sign each section if you wish to OPT IN.

If you do not sign a section you are automatically opted OUT for that service.

SUMMARY CARE RECORD (SCR)

NHS England has introduced the Summary Care Record, which will be used in emergency care.
The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse 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 professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

I have read the information above, carefully, and wish to be **OPTED IN** for this service. I know that I can change my mind at any time and will notify the practice, in writing with a signature, giving adequate notice.	
Signature:	**Date:**

SMS (Text) Messaging Service

We may use SMS messaging to communicate with patients who have provided us with a mobile number, for the purposes of health education/promotion, data collection, test results and appointment reminders.

Information sent via an SMS message will be generic and no information which identifies an individual patient such as name, address, or other items of personal detail will be included. Information stating the reason for the message will be kept to a minimum.

Where an important matter is to be conveyed to the patient a letter or other reliable method will be used.

We **do not** currently offer a reply facility unless requested by us in the message.

I have read the information above, carefully, and wish to be **OPTED IN** for this service. I know that I can change my mind at any time and will notify the practice, in writing with a signature, giving adequate notice.	
Signature:	**Date:**

Email Services

We may use email messaging to communicate with patients who have provided us with an email address, for the purposes of health education/promotion, data collection, test results, reminders and other medical information.

If you are expecting correspondence via this method, which you haven't received, please check your spam folder.

If you are OPTING OUT of this service, you should NOT include your email address on the front page.

I have read the information above, carefully, and wish to be **OPTED IN** for this service. I know that I can change my mind at any time and will notify the practice, in writing with a signature, giving adequate notice.	
Signature:	**Date:**

Please use this space for any other comments:

GMS1 SUPPLEMENTARY QUESTIONS

PERSONAL DETAILS	
Title	Mr/Mrs/Ms/Miss
Forenames	
Surname	
Date of Birth	

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 (eg. 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.