**Patient’s details**

*Please complete in BLOCK CAPITALS and tick as appropriate*

Mr Mrs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of birth |  |  |  |  |  |  |  |
| NHSNo. |  |  |  |  |  |  |  |  |  |  |

Miss

Ms Surname

First names

Previous surname/s

Male Female Home address

Town and country of birth

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

***Signature confirming my consent to join the NHS Organ Donor Register***

Pancreas

**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*](http://www.organdonation.nhs.uk/) *or call 0300 123 23 23 to register your decision.*

**Family doctor services registration** *GMS1*

**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*](http://www.blood.co.uk/) *or call 0300 123 23 23.*

052019\_006 Product Code: **GMS1**

**NHS England use only** Patient registered for GMS Dispensing


#  To be completed by the GP Practice

*GMS1*

**Family doctor services registration**

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.

Practice Stamp

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

*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:**1. I understand that I may need to pay for NHS treatment outside of the GP practice
2. 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
3. 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 orPRC 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. |

**Consent Form**

**DR J J WIJERATNE & PARTNERS**

**BELMONT HEALTH CENTRE**

**516 KENTON LANE, HARROW, MIDDLESEX HA3 7LT**

|  |  |
| --- | --- |
|  Dr Wijith Wijeratne, BM, MRCP(UK) |  Dr I Ekneligoda MD, MD(Paed), MRCPCH, DFFP |
|  Dr S Wijendra, MB, BS, LRCP, FRCS, FRCS(Edin) |  Dr J Tanna, MBBS, BSc, MRCGP, DRCOG |
|   |  Dr M Munasinghe, BSc, MBChB, MRCP, MRCGP, DRCOG  |
|  **Tel: 020 8863 6863** | **Appointments Tel: 020 8861 5663** |  **Fax: 020 8424 0542** |
|  | **(www.belmonthealthcentre.co.uk)** |  |

Name: ………………………………………………………………………………………….

Date of Birth: …………………………………………………………………………………..

Address: ……………………………………………………………………………………….

…………………………………………………………………………………………………..

I give permission for the following person/s:

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify) …………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify) …………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

☐ Mother ☐ Father ☐ Daughter ☐ Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

☐ Other (please specify) …………………………………………………………………….

To be able to do the following on my behalf at Belmont Health Centre (Dr J J Wijeratne & Partners)

☐ Book appointments ☐ Cancel appointments

☐ Request prescriptions ☐ Collect prescriptions

☐ Surgery to leave messages with this person relating to myself ☐ Check test results

☐ I understand that it is my responsibility to inform the surgery if the above information changes in the future.

Signature: ……………………………………………………………………………………

Date: …………………………………………………………………………………………

|  |
| --- |
| **Electronic Prescription Service****Patient Nomination Request** |
| **Patient name** ………………………………………………………………………………………………**Address** …………………………………………………………………………………………………………………………………………………………………………………………………………………………… Telephone Number…….………………………………………………………………………………… DOB………………….………………………………………………………………………………………. NHS Number ……………………………………………………………………………………………… |
| **I am the patient named above. Nomination has been explained to me by staff at my GP practice/community pharmacy/appliance contractor. I have also been given a leaflet about this. I have read the Nomination Leaflet and understand what I have to do. I will inform the pharmacy that I have nominated them.****I am the patient’s parent, guardian, carer, patient advocate (delete as appropriate) and nominating on behalf of the above named patient****NAME: ADDRESS:** |
| Name and address of nominated dispenser: |
| **Patient/Patient Representative Signature:** …………………………………………………………………………**Patient/Patient Representative Phone Number:** …………………….…………………………………………**Patient Telephone Numbers: Home:****Mobile:****Work:****Patient email address:** ………………………………………………………………….…………………………….**Staff Signature:** ………………………………………………………………….…………………………….**Date**………………………………………………………………….……………………………. |

EPS-NOM-001

 DR J WIJERATNE & PARTNERS

**Patient Online Registration Form**

**Access to GP online services**

****

Surname

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  | I wish to |
| First name |  |  |  |  |
|  |  |  |  | have |
|  |  |  |  |  |  |
|  |  |  |  |  |  | access to |
| Date of birth |  |  |  |  |
|  |  |  |  | the |
|  |  |  |  |  |  |
|  |  |  |  |  | following |
| Address |  |  |  |  |
|  |  |  |  |  |  | online |
|  |  |  |  |  |  | services |
| Postcode |  |  |  |  | (tick all |
|  |  |  |  |  |  | that |
| Email address |  |  |  |  | apply): |
|  |  |  |  |  |  |
| Telephone number | Mobile number |  |  |  |  |
|  |  |  |  |  |  |  |
| 1. | Booking appointments |  |  |  |  |  |
|  |  |  |  |  |
| 2. | Requesting repeat prescriptions |  |  |  |  |  |
|  |  |  |  |  |
| 3. Accessing my detailed coded medical record |  |  |  |
|  |  |  |

**Application for online access to my medical record**

I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1. | I have read and understood the information on the reverse of this form |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | 2. | I will be responsible for the security of the information that I see or download |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | 3. | If I choose to share my information with anyone else, this is at my own risk |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | 4. | I will contact the practice as soon as possible if I suspect that my account |  |  |  |
|  |  | has been accessed by someone without my agreement |  |  |  |
|  | 5. | If I see information in my record that it not about me, or is inaccurate I will |  |  |  |
|  |  | log out immediately and contact the practice as soon as possible |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | Patient |  |  |  | Date |  |  |  |
|  | Signature |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | **For practice use only** |  |  |  |  |  |  |
|  |  |  |  |  |
|  | **Photo ID** (Please tick) | **Address ID (last 3 months)** (Please tick) |  |  |
|  |  |  |  |  |
|  | Passport | Utility Bill |  |  |
|  | Driving Licence | Bank or credit card statement |  |  |
|  | Bus Pass | Benefit statement |  |  |
|  | Firearms Licence | *(NOT mobile phone bill please)* |  |  |
|  | Other |  |  | *Other* |  |  |
|  | **Receptionist Initials** |  |  |  |  |  |  |

**Important Information – Please read before returning this form**

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.

**It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**

If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

**If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**

**Before you apply for online access to your record, there are some other things to consider.**

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

**Forgotten history** There may be something you have forgotten about in your record that you might findupsetting.

**Abnormal results or bad news** If your GP has given you access to test results or letters, you may seesomething that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

**Choosing to share your information with someone** It’sup to you whether or not you share yourinformation with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure.

**Coercion** If you think you may be pressured into revealing details from your patient record to someone elseagainst your will, it is best that you do not register for access at this time.

**Misunderstood information** Your medical record is designed to be used by clinical professionals to ensurethat you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

**Information about someone else** If you spot something in the record that is not about you or notice anyother errors, please log out of the system immediately and contact the practice as soon as possible.

**Proxy Access:** Parents may request a proxy access to theirchildren’srecords; this will cease automaticallywhen the child reaches the age of 13. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

**Welcome to the Belmont Health Centre – ADULT FORM**

Thank you for completing this questionnaire. All information you give is confidential and will be held on your medical records. Please can you:

Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**

Provide a specimen of Urine

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth |  |
| Email address  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do NOT wish to be contacted by email or SMS. ☐ |
| **Who should we contact in an emergency?** |
| Name  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship |  |
| Telephone number |  |

**Ethnicity**

What is your country of birth? What is your first language?

☐ White British

☐Other White ethnic group

☐ Black British

☐ Black Caribbean

☐ Black African

☐ Black other

☐ Other Black ethnic group

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Vietnamese

☐ Other Asian ethnic group

☐ I do not wish to state my ethnic group

☐ Other ethnic group (please state):

**Religion**

☐No religion

☐Christian

☐Buddhist

☐Hindu

☐Jewish

☐Muslim

☐Sikh

☐Any other religion (please state

**Social Habits**

**Smoking**: please tick the box that applies to you

☐I am a SMOKER How many per day?

☐I am an EX-SMOKER When did you stop smoking?

☐I have NEVER SMOKED

**Alcohol:** 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?

*One standard drink is: 1 single measure of spirits, 1 small glass of wine, half a pint of beer, lager or cider. A bottle of wine is 9 units*

☐1-2

☐3-4

☐5-6

☐7-9

☐10+

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

☐Never

☐Less than monthly

☐Monthly

☐Weekly

☐Daily or almost daily

**Measurements**

**Height:** Feet/inches: Metres:

**Weight:** Stones: Kg:

**Waist:** Inches: Centimetres:

**Exercise:** Do you take exercise that lasts for at least 20 minutes per session? ☐ Yes ☐No

If yes, how many times a week? ☐ 1 ☐ 2 ☐ 3+

**Do you work?**

☐Employed ☐Self-employed ☐Unemployed ☐Homemaker ☐Student ☐Retired

What is your current occupation?

**Carer/Housebound Information**

Do you have a Carer? ☐ Name and contact no. of Carer:

Are you a Carer? ☐ Name of person you care for:

Are you housebound? ☐

**Family History**

Have any of your close family (parents/brother/sister) had any of these illnesses or conditions?

|  |  |  |
| --- | --- | --- |
|  |  | Details, for example Father, Mother, Sister |
| ☐ | Raised Cholesterol |  |
| ☐ | Stroke |  |
| ☐ | Heart Disease before the age of 60 |  |
| ☐ | Heart Disease after the age of 60 |  |
| ☐ | Asthma |  |
| ☐ | Cancer |  |
| ☐ | Diabetes |  |

**Past Medical history:** Please list with dates and **significant** current or past illnesses, operations or allergies

|  |  |
| --- | --- |
| **Illness, Operation Or Allergy** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**Women Only**

Are you pregnant? ☐Yes ☐No If yes, when is your baby due?

When was your last cervical smear examination? Result:

When was your last Breast screening X-ray (mammogram)? Result:

What type of contraception do you use, if any?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ | Oral contraception (the Pill) | ☐ | Diaphragm | ☐ | Contraception not needed |
| ☐ | Condom (sheath) | ☐ | Patch (transdermal) | ☐ | No current contraception |
| ☐ | Depot Injection | ☐ | Ring (Nuvaring) | ☐ | Other (please state) |
| ☐ | Coil (IUD-Intrauterine) | ☐ | Implant (Implanon/Nexplanon) |

**Drugs and Medications:** If you require any medication, you must make an appointment with a Doctor for this to be issued. Please bring your repeat medication slip or attach your last prescription.

**Thank you for your time and help in completing this questionnaire**

*Issuing of the registration documents does not guarantee registration with this Practice*

**For office use only**

**Proof of ID seen:** ☐ Yes ☐ No

Document Initials/Date

**Proof of address seen (e.g. Utility bill):** ☐ Yes ☐ No

(NPM)

Appointment Booked Date