Devon Square Surgery
44 Devon Square, Newton Abbot, Devon TQ12 2HH
Contact: 01626 332182 Email: devon.square@nhs.net

APPLICATION TO REGISTER AN NHS PATIENT

PATIENT DETAILS please complete in BLOCK CAPITALS and tick where appropriate.
Please can you provide some form of identification with your completed registration form.

DO YOU HAVE ANY COMMUNICATION NEEDS THAT WE NEED TO BE AWARE OF? (*If yes please complete an accessible information form)*	Yes ☐ No ☐

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ other ☐		Surname:	
Date of Birth:		First name/s:	
NHS No: (if known)		Previous name/s:	
Male ☐ Female ☐ Other (Please specify):		Town and country of birth:	
Home Address:			
Postcode:		Mobile Telephone Number:	
Home Telephone number:		Work Telephone number:		Preferred Method of contact Mobile ☐ Home number ☐ Email ☐
Email Address -			

If you are registering a child under 5, do you wish the above child to be registered with the doctor for Child Health Monitoring?	YES ☐ NO ☐

Please help us trace your previous medical records by providing the following information

Your Previous address in the UK:	
Name of Previous doctor while at this address:	
Address of Previous Doctor:	

If you are from abroad:

Your first UK address where registered with a GP:	
If previous resident in the UK, date of leaving:	
Date you first came to live in UK:	

Armed forces:

Have you ever served in the armed forces? Which Service?		YES ☐ NO ☐ RAF ☐ NAVY ☐ ARMY ☐	
Service Number and Rank			
Name & address of last Military Medical Centre: Practice Tel Number			
Residential address on leaving the service if different			
Enlistment Date		Leaving Date	
Address before enlisting:			
Are you still a reservist?		YES ☐ NO ☐	
Do you have an FMed 133? Please hand in with this form Do you give consent for us to request a copy of your full Defence Medical Services health record if required? If yes please ask reception for a consent form (Admin send form to MOD)			

NHS ORGAN DONOR REGISTRATION
All adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups. For more information go to the organ donor website

NHS BLOOD DONOR REGISTRATION If you would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood sign this box.		
Signature confirming consent to inclusion on the NHS Blood Donor Register		
Have you given blood in the last 3 years?	YES ☐ NO ☐	DATE

YOUR ETHNICITY AND LANGUAGE
The NHS requires all medical records to show patients ethnic origin together with native or first language.

WHITE: British or Mixed British		ASIAN: Pakistani or British Pakistani	
WHITE: Irish		ASIAN: Bangladeshi or British Bangladeshi	
WHITE: Any other background		ASIAN: Any other background	
MIXED: White and Black Caribbean		BLACK: Caribbean	
MIXED: White and Black African		BLACK: African	
MIXED: White and Asian		BLACK: Any other background	
MIXED: Any other background		CHINESE:	
ASIAN: Indian or British Indian		ANY OTHER ethnic group	
What is your first spoken language?		I prefer not to specify my ethnic group.	

Do you require a translator?	YES ☐ NO ☐
We will record your first spoken language as ENGLISH unless you specify otherwise.	

DO YOU HAVE A LIVING WILL OR AN ADVANCED DIRECTIVE TO REFUSE SPECIFIC MEDICAL TREATMENT? FOR EXAMPLE RELIGION	YES ☐ NO ☐	IF YES PLEASE GIVE DETAILS AND SUPPLY A COPY OF THE DOCUMENT:

YOUR FAMILY HEALTH HISTORY

Have your parents, brother(s) or sister(s) suffered from any of the problems listed below-
Please tick and then **circle which family member**

Diabetes		Father ☐ Mother ☐ Sister ☐ Brother ☐
Asthma		Father ☐ Mother ☐ Sister ☐ Brother ☐
High Blood Pressure		Father ☐ Mother ☐ Sister ☐ Brother ☐
Stroke		Father ☐ Mother ☐ Sister ☐ Brother ☐
Heart Disease		Father ☐ Mother ☐ Sister ☐ Brother ☐

YOUR OWN HEALTH
HEALTH PROBLEMS: Please **tick if you have a history of any of the following** 12 health problems……

Cancer		Coronary Heart Disease, Heart Failure, or Arterial Fibrillation	
Dementia or Alzheimer's		Depression or Mental Health problems	
Hypertension (High Blood Pressure)		Kidney Disease	
Respiratory Difficulties (Asthma or COPD)		Stroke or Transient Ischemic Attacks	
Diabetes		Learning Difficulties	
Epilepsy		Thyroid Disease	
If you have any other history or important illnesses or disabilities not mentioned above please give details here:			

ALLERGIES: Please list any allergies you have:	

MEDICATION: are you taking any regular / repeat medication? If so please make a list below OR attach the most recent repeat prescription list / form from your previous GP surgery, this information is essential to enable your new GP to authorise future repeat medication.
CHEMIST: Which chemist (and branch) would you like you medication to be sent to?

FOR FEMALES AGED 15 TO 65 - if you use any form of contraception please circle which one.			
Oral Pill	Patches	Requires BP check once a year	Details of contraception medication if known
If you do use contraception when was your last check-up / review with GP or Nurse?			Date:
If you have a Coil or Implant, approximately what date was it fitted?			Date:
If you have depo injections when was your last one?			Date:
Have you had a recent smear?			Date:

YOUR LIFESTYLE

EXERCISE: Please **circle which of these terms best describes how much exercise you take on a regular basis.**			
None	Light	Moderate	Heavy
Body Measurements	Height	Weight	Waist Circumference

YOUR SMOKING STATUS (Please tick boxes and complete with information as appropriate)

Never Smoked		N/A	
Ex- Smoker		Date Stopped?	
Cigarette Smoker		How many per day?	
Roll Own Cigarettes		How many per day?	
Cigar Smoker		How many per day?	
Pipe Smoker		How many ounces per week?	

If you wish to stop smoking our trained advisors can help you

YOUR ALCOHOL CONSUMPTION	SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	YOUR SCORE
How often do you have a drink containing alcohol	Never ☐	Monthly or less ☐	2-4 times per month ☐	2-3 times per week ☐	4+ times per week ☐	
How many unit of alcohol do you drink on a typical day when you are drinking?	1-2 ☐	3-4 ☐	5-6 ☐	7-9 ☐	10+ ☐	
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 ☐	
					TOTAL SCORE	

IF YOUR SCORE IS 5 (Five) or above please complete the additional questions below.

Additional Questions if you scored 5 or more above.	SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	YOUR SCORE
How often during the last year have you found that you are not able to stop drinking once you have started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	

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 needed an alcoholic drink in the morning in to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you had a feeling of guilt or remorse after 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 ☐	
Have you or somebody else been injured as a result of your drinking?	No ☐		Yes but not in last year ☐		Yes during the last year ☐	
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 last year ☐		Yes during the last year ☐	
					TOTAL SCORE	

ARE YOU A CARER?	YES ☐ NO ☐	**IF YES PLEASE COMPLETE A SEPARATE CARERS FORM**
DO YOU HAVE A LIVING WILL OR AN ADVANCED DIRECTIVE TO REFUSE SPECIFIC MEDICAL TREATMENT? FOR EXAMPLE RELIGION.	YES ☐ NO ☐	**IF YES PLEASE GIVE DETAILS AND SUPPLY A COPY OF THE DOCUMENT**

NEXT OF KIN

In order that you're GP can do all they can to help, it is important that they are aware of your next of kin. It would be helpful, therefore if you could provide the information requested below. A Next of Kin is usually is a close family relative or relatives. Patients are often asked to nominate a next of kin when registering with their GP or if you are admitted to hospital. The practice will not be able to share any clinical information with the next of kin without written consent of the patient concerned.

Name:			Relationship to you:		
Address:					
Mobile		Landline		Email	
Permission to contact next of kin in an emergency	YES ☐ NO ☐				

SIGNATURE OF PATIENT :	
OR SIGNATURE on behalf of a patient:	
DATE:	
Please note by signing this form you are consenting to receiving texts and emails from the practice	

NOTE: Please fill in the supplementary questions on the following pages before returning your registration form to the surgery. Thank you

SHARING YOUR NHS PATIENT DATA

Information sharing in the NHS is subject to rigorous regulation and governance to ensure your full identifiable and personal medical data is kept confidential and only ever seen by carefully vetted doctors, nurses and administrative staff responsible for overseeing your care.
With the development of information technology the NHS will increasingly be sharing key information from your GP medical notes with Out of Hours GP Services, Hospital A&E Units, Community Hospitals, Community Nurses all of whom may at various times in your life be looking after you. Sharing information can improve both the quality and safety of care you receive and in some cases can be vital in making life-saving decisions about your treatment.

There are currently two different elements of "sharing NHS patient information"

- **SCR = The NHS Summary Care Record**
- **EDSM = The Enhanced Data Sharing Model "SystmOne"**

We ask you please to read the information on this document carefully and complete the relevant fields on the attached form and return it to your GP surgery.

SCR = NHS SUMMARY CARE RECORD

The NHS Summary Care Record was introduced many years ago to help deliver better and safer care; it contains basic information about:

- Any allergies you may have,
- Unexpected reactions to medications, and
- Any prescriptions you have recently received.

The intention of the SCR is to help clinicians in Hospital A&E Departments and GP 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians are only allowed to access your SCR record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree (explicit consent).

Patients under 16 years have an NHS Summary Care Record created for them so if you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.

EDSM = ENHANCED DATA SHARING MODEL "SYSTMONE"

The database and software used to store your GP health record is called "SystmOne" it is a very secure national system used by over 2000 GP practices and 4800 NHS organisations including GP out of hour's services, children's services, community services and some hospitals. All the GP Practices in the Newton Abbot locality use this same confidential clinical computer system. The system gives your GP the facility to share your record with other NHS health providers that use the same clinical computer system and are involved in your care for example the local Community Nurses who may look after you if you when you leave hospital or become terminally ill or housebound. Allowing your GP to share your record in the "SystmOne" database helps to deliver better and safer care for you. It is the policy of all local GP practices to automatically opt registered patients into "SystmOne" sharing unless they expressly decline. Those patients who choose to decline are able to determine if their data is "shared out" and/or "shared in"

Sharing OUT controls whether information recorded at our GP practice can be shared with other NHS health care providers.

Sharing IN determines whether or not our GP practice can view information in your record that has been entered by other NHS services who are providing care for you or who may provide care for you in the future (*that you have consented to share out*).

To The GP Medical Practice Admin Support Team

NHS PATIENT INFORMATION SHARING – MY CHOICES

Please complete the boxes below to detail your personal decisions regarding the aspects of NHS patient data sharing:

It is very important you sign this form to say that you understand and accept the risks to your personal health care if you do decide to opt out of SCR or EDSM. Hand the completed form in to your GP Surgery; they will scan this form into your NHS GP Medical Records and enter the appropriate computer codes.

GP Practice	

Patients full NAME	
Patients DATE OF BIRTH	

1. SCR - NHS SUMMARY CARE RECORD

Please tick only one box.

- ☐ Express consent for medication, allergies and adverse reactions only
- ☐ Express consent for medication, allergies, adverse reactions and additional information
- ☐ Express dissent – Patient does not want a summary care record and fully understands the risks involved with this decision

2. EDSM – ENHANCED DATA SHARING MODEL "SystmOne"

Sharing Out – Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that may care for you?

- ☐ YES share data with other NHS organisations
- ☐ NO do NOT share any data recorded by my GP Practice; I fully accept the risks associated with this decision

Sharing In – Do you consent to your GP Practice viewing data that is recorded at other NHS organisations and care services that may care for you?

- ☐ Consent Given
- ☐ Consent Refused; I fully accept the risks associated with this decision.

Patient's Full SIGNATURE		**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 you 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 (eg. 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 on 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

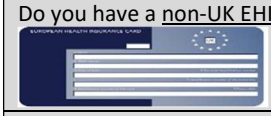
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	
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 CARE (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**

Country Code:		**Name**	
Given Names		**Date of Birth**	
Personal Identification Number		**Identification number of the institution**	
PRC Validity period	**Expiry date**	**From:**	**TO:**

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 of the 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.

For Office Use:

REGISTERED GP:	
GP SIGNATURE:	
DATE:	

Devon Square Surgery

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services

1. Booking appointments
2. Requesting repeat prescriptions
3. Accessing my detail coded record

I wish to access my medical record online and understand and agree with each statement

1. I have read and understood the information leaflet provided by the practice
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.

Signature	Date

For practice use only

Registered for online services		Date:
Identity verified by (initials)	Date:	Method Vouching ☐ Vouching with information in record ☐ Photo ID ☐
Repeats authorised:		Date:
Dr.:		Task sent:
Level of record access enabled Appointment/Repeats Detailed coded Full record		Notes / explanation