

**THE BROW**

**BURGESS HILL**

**WEST SUSSEX, RH15 9BS**

**TELEPHONE: 01444 246123**

[www.browmedicalcentre.nhs.uk](http://www.browmedicalcentre.nhs.uk/)

**Under 5’s Application to register at**

**The Brow Health Centre**

Welcome to the Brow Health Centre.

There is no need to provide photo ID to register a child under 5 years old. However, if you have arrived from outside the UK and have a BRP card or Visa documentation we need to see this and the passport. Please bring along to Reception your child’s red book or other immunisation record.

In order to register a child with the Surgery we must have one parent/guardian registered at the Brow and living at the same address as the child.

As soon as we receive the fully completed forms, signed by you, we can process your registration, which can take up to 5 working days. **If you are currently on medication, please ensure you have sufficient supplies (ideally 3 weeks’ worth) from your previous GP as it can take a few weeks to receive notes from your previous GP.**

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| New patient registration and health questionnaire |

The following questions have been designed to help your new GP get to know you and your medical history. The information you provide will be handled confidentially.

We recommend that all new patients have a general health check soon after registering. Please speak to Reception to arrange this if you would like to do so.

|  |  |
| --- | --- |
| **Surname** |  |
| **Forename (s)** |  |
| Preferred name |  |
| Date of birth |  |
| Address |  |
| Post code |  |
| Telephone home |  |
| Telephone work |  |
| Mobile phone |  |
| Email address (needed for Patient Access) |  |
| Religion |  |
| Town and Country of birth |  |
| Name and address of previous doctor |  |
| Address and post code whilst registered there |  |
| First language |  |
| Do you need a translator? | Yes   No |
| *We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know.* | |
| Please tell us what communication requirements you have (eg Braille, large print, etc) | |
| Do you consider yourself to have a disability? If yes please give details: | Yes  No  Do not wish to say |
| Next of kin: name and contact telephone  Relationship to you? |  |

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| Medication |

Please list any medications you are taking and reasons why, including any not prescribed by a doctor. If you have a ‘repeat’ please attach a copy.

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| **Medication name** | **Dose (strength and number)** | **Reason** |
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| **Preferred Pharmacy** – please indicate if you would like to nominate a chemist for electronic prescriptions | |
| **Nominated pharmacy** |
| BootsWilliams  Jessica’s  Hopkins  Tesco (Jane Murray Way)  Other (please specify) |

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| Your medical history |

Have you ever suffered from any of the following? If you answer yes to any of them please put further details in the section below.

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| --- | --- | --- | --- | --- | --- |
| Heart attack | Y | N | Asthma | Y | N |
| Angina / Ischaemic heart disease | Y | N | Chronic airways disease (COPD) | Y | N |
| Stroke | Y | N | Eczema | Y | N |
| Diabetes | Y | N | Hayfever | Y | N |
| Epilepsy | Y | N | Thyroid problems | Y | N |
| High blood pressure | Y | N | Cancer | Y | N |
| High cholesterol | Y | N | Stomach ulcer | Y | N |
| Blindness | Y | N | Mental illness/depression | Y | N |
| Glaucoma | Y | N | Kidney disease | Y | N |
| Please detail any illnesses or operations you have had (with dates if possible) | | | | | |

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| Allergies |
| Do you have any diagnosed allergies or sensitivities? Yes  / No |
| If yes, please give details: |

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| General Health |
| Height: Weight: BP: |
| How many times a week do you exercise? |
| How best can you describe the exercise you do?  None  Light   Moderate  Vigorous  *If you are interested in losing weight or increasing your exercise levels please contact Mid Sussex Wellbeing Service on 01444 477191 or www.midsussex.westsussexwellbeing.org.uk* |

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| Family History |

Please TICK if your close blood relatives have any of the following health problems or other inherited disease? Give details if you can (eg ‘mother aged 45’)

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| --- | --- | --- | --- |
|  | **Family member** |  | **Family member** |
| Heart disease aged under 60 |  | Diabetes |  |
| Heart disease aged over 60 |  | Asthma |  |
| Cancer (include type if known) |  | Stroke / CVA |  |
| Parental hip fracture |  |  |  |

**If you wish to setup patient access the GP Online Services for your child, you will need to complete a proxy form found on our website or available as a paper form from Reception.**

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| **Consent –** this section MUST be completed |
| It is sometimes necessary to phone or text you in order to change an appointment, arrange tests, or give you information regarding any treatment you may be having or results.  Would you please indicate below if you are happy for a Doctor or member of The Brow staff to leave a message on your answer machine, send an SMS text or contact you by email if you are personally unobtainable.  **Consent:**  I give my permission for the practice to leave messages on my telephone answer machine  I give my permission for the practice to contact me via my email address  I give my permission for the practice to contact me via my mobile/SMS text  messaging  Preferred method of contact:  Home tel  Mobile  Email  Signed:  Date: |

**Information for new patients: about your Summary Care Record**

Dear patient**,**

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form below.

\* **Express consent for medication, allergies and adverse reactions only.**You wish to share information about medication, allergies for adverse reactions only.

\* **Express consent for medication, allergies, adverse reactions and additional information.**You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

\* **Express dissent for Summary Care Record (opt out).**Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions. You are free to change your decision at any time by informing your GP practice.

**SUMMARY CARE RECORD PATIENT CONSENT FORM**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

**Yes – I would like a Summary Care Record**

Express consent for medication, allergies and adverse reactions only.

Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

Express dissent for Summary Care Record (opt out)

If you are filling out this form on behalf of another person, enter your name and sign below:

|  |  |
| --- | --- |
| Name: |  |
| Signature: |  |
| Date: |  |

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| --- | --- | --- |
| **Please tick one:** | Parent  Legal Guardian | Lasting power of attorney for health and welfare |
|  |  |  |

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

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| To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.  **Summary Care Record consent preference** |  |  |
| The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only) | 9Ndm. |  |
| The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn. |  |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo. |  |

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| **FOR OFFICE USE ONLY – Please tick when completed:** |
| GMS1  ID  Registration form checked  Practice leaflet  Red Book or Immunisation Record |
| **Staff member taking registration** |
| **Date:** |



*GMS1*

**Family doctor services registration**

**Patient’s details**

*Please complete in BLOCK CAPITALS and tick*

*as appropriate*

Mr Mrs

Miss

Ms Surname

Date of birth

First Names

NHSNo.

Previous surname/s

Town and country

Male Female 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 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\*** *\*Not all doctors are*

# I live more than 1.6km in a straight line from the nearest chemist *authorised to*

*dispense medicines*

I would have serious difficulty in getting them from a chemist

**Signature of Patient**

**Signature on behalf of patient**

Date / /

**What is your ethnic group?**

Please tick one box that best describes your ethnic group or background from the options below:

**White:** British Irish Irish Traveller Traveller Gypsy/Romany Polish

Any other white background (please write in): ................................................................................................................................................................................................................................

**Mixed**

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed background (please write in): ...............................................................................................................................................................................................................................

**Asian or Asian British:**

Indian

Pakistani

Bangladeshi

Any other Asian background (please write in): .................................................................................................................................................................................................................................

**Black or Black British:**

Caribbean

African

Somali

Nigerian

Any other Black background (please write in): .................................................................................................................................................................................................................................

**Other ethnic group:**

Chinese

Filipino

Any other ethnic group (please write in): ...............................................................................................................................................................................................................................

**Not stated:**

Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

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

062021\_006 Product Code: **GMS1**



*GMS1*

**Family doctor services registration**

**To be completed by the GP Practice**

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 / /

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| **SUPPLEMENTARY 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**   **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:** |  |

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| --- | --- | --- | --- |
| **Complete this section if you live in an EU 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 (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 Business Service Authority for the purpose of recovering your NHS costs from your home country. | | | |

**The Brow, Burgess Hill, West Sussex, RH15 9BS  
01444 246123**Website: [**www.browmedicalcentre.nhs.uk**](http://www.browmedicalcentre.nhs.uk/) **Email:** [**sxicb-wsx.brow-burgesshill@nhs.net**](mailto:sxicb-wsx.brow-burgesshill@nhs.net)

**INFORMATION FOR HEALTH VISITOR**

**(HEALTHY CHILD PROGRAMME)**

**ON CHILDREN 0 – 5 YEARS OLD**

Welcome to the Brow Health Centre. One of the Health Visitors will contact you soon to introduce themselves.

In the meantime, we would be very grateful if you could complete the following form and hand it to the Receptionist.

If you need to contact us immediately, please call us on 01273 696011 Extn. 6606

**PLEASE COMPLETE IN BLACK INK AND CAPITAL LETTERS**

|  |  |
| --- | --- |
| **NAME OF CHILD** |  |
| **DATE OF BIRTH** |  |
| **CURRENT ADDRESS** |  |
| **LANDLINE NUMBER** |  |
| **MOBILE NUMBER** |  |
| **EMAIL ADDRESS** |  |
| **PARENTS NAMES** |  |
|  |
| **PARENTS DATE OF BIRTH** |  |
|  |
| **PREVIOUS ADDRESS** |  |
| **PREVIOUS GP DETAILS** |  |