Save time and do it online!

Register today and see how you can make your life a little easier!

82 Bulkington Lane, Nuneaton, CV11 4SB
www.whitestonesurgery.org
Tel: 02476 641911 Fax: 02476 343286

whitestone SURGERY
the patient first and always

APPLICATION FORM FOR AN ONLINE ACCESS ACCOUNT

**One application form per patient is required*

Surname: ..... Title: Mr / Mrs / Miss / Ms (please circle)

First name/s: .....

Address: .....

..... Postcode .....

Date of Birth*: ..... (*you must be 13 to qualify for this service)

Tel Home ..... Tel Work ..... Tel Mobile .....

Email: .....

I would like to apply for an Online Access Account which gives me the ability to book routine GP appointments, cancel my appointments, request my repeat medication, and change any address/telephone number over the internet.

Please tick one:

- ❑ I will collect the letter containing my account details from reception in person and will bring an appropriate form of photo identification.
- ❑ I would like to nominate a friend/relative/carer to collect my account details on my behalf. I understand the person collecting my details will have access to my confidential account information and I take full responsibility for any misuse of my account or breaches of confidentiality that may occur as a result.

Whitestone Silver Surfers

Whitestone Surgery Silver Surfers are available to anyone who needs help with online access

PATIENT Participation GROUP

The full name of the person I nominate to collect my account details on my behalf is:

Nominated Person .....

I have read and agree with all the terms and conditions of use as detailed on the Online Access Information Sheet (available at reception).

Signed .....

Print Name ..... Date .....

Please return this form to the surgery

NHS ELECTRONIC PRESCRIPTION SERVICE

NHS Electronic Prescription Service

This is a free, confidential, safe service that can make getting your prescriptions quicker and easier. Instead of having a paper prescription, your doctor can send an electronic prescription to the pharmacy of your choice.

To take advantage of this service fill out the details below and detach this section of the form and take it to your preferred pharmacy.

Surname: ..... Title: Mr / Mrs / Miss / Ms (please circle)

First name/s: .....

Address: .....

..... Postcode .....

Doctor's Name ..... Dr. Sacha Simon .....

Surgery Address ..... Whitestone Surgery, 82 Bulkington Lane, ...

..... Nuneaton CV11 4SB .....

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NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Mobile number

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

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

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHSOrgan 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 as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood 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 consent to inclusion on the NHS Blood Donor Register **Date**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

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PLEASE REMEMBER TO BRING IN (1) PROOF OF IDENTITY (2) PROOF OF RESIDENCE AND (3) COPY OF ANY REPEAT PRESCRIPTIONS NEEDED

CONFIDENTIAL QUESTIONNAIRE

Full name ……..……..

Date of Birth ……..... Marital status: Married/Divorced/Single/Widowed

Address ……. Post Code …….

Telephone No …… Mobile No ……

Email address ……..... …….

Emergency Contact (compulsory) /Next of Kin (Full name/relationship/contact details ……

…… Can they receive messages/discuss on your behalf/ Yes/No

Previous Address …….

Name & Address of Previous Doctor ……..

Occupation …….. Ethnicity …… First Language ……...

Do you suffer from or have a history of any of the following: (Please circle if applicable)

Hearth disease/Stroke/Diabetes/Asthma/Chronic Obstructive Pulmonary disease/Epilepsy/Cancer/Dementia/ Hypothyroidism/High blood pressure/Mental Health problems/Learning disabilities/Depression/Chronic Kidney Disease

Is there any family history of any of the above? YES/NO. If yes, please state which: ……

Have you had any operations? YES/NO If yes, please state: ……

Please list any medication (tablets, injections, creams, inhalers) you use regularly, even if bought over the counter:

……..

Are you allergic to any medicines YES/NO If yes, please state: ……..

Are you a carer for someone else? YES/NO If yes, who are you caring for? Name/Relationship/details ……

Do you have a carer? YES/NO. If yes, who? Name/Relationship/details ……..
…….
(we will request their permission to put their name on our database)

Are you a smoker/Ex-smoker/Non-Smoker (please circle). If yes, how much? CIGS per day …….Pipe oz ……

What is your weekly alcohol intake? ……. . Do you take any regular exercise? YES/NO Daily/Monthly/Weekly

Last immunisation for: Tetanus …….. Polio ……..Influenza ……..

What is your height? …… What is your approximate weight ……

If you would like to become a member of our virtual patient participation group (no meetings to attend but run by e-mail and internet) please put your email address below.

……..

FOR WOMEN ONLY:		**CHILDREN ONLY:**			
When did you last have a cervical smear?		Triple Vaccine Whooping Cough included?	1st	2nd	3rd
Are you in need of contraceptive advice	**YES/ NO**	HIB Meningitis Vaccine MMR (Measles/Mumps/Rubella)	1st	2nd	3rd
Are you immune to Rubella/German Measles	**YES/ NO**	Pre School Booster	Age 4 -5 years		
		Rubella (German Measles)	Age 10 – 14 years		
		Having school booster	Age 15 – 16 years		

Fast Alcohol Screening Test (FAST)

WHO designed by www.effectivepi.co.uk. Free from copyright.

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

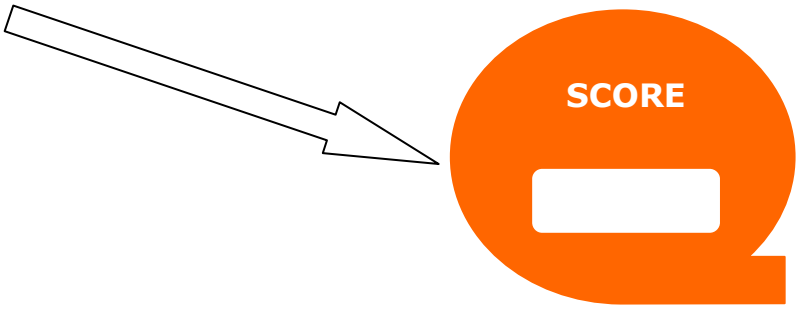
Remember, drinks poured at home are usually bigger

Questions	Scoring system					Your score
	0	1	2	3	4	
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often do you have 8 units (men) / 6 units (women) or more on one occasion?						
If you scored zero above, then FAST is negative and you may stop. If you scored 1-4 then carry on.						
How often in the last year have you not been able to remember what happened when drinking the night before?						
How often in the last year have you failed to do what was expected of you because of drinking?						
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

An overall total score of 3 or above is FAST positive and may indicate hazardous or harmful drinking.

Score from FAST (other side)



Remaining FAST questions

Questions	Scoring system					Your score
	0	1	2	3	4	
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often do you have a drink that contains alcohol?						
How many units do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
How often in the last year have you found you were not able to stop drinking once you had started?						
How often in the last year have you needed an alcoholic drink in the morning to get you going?						
How often in the last year have you had a feeling of guilt or regret after drinking?						
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

0 – 7	Indicates Sensible Drinking
8 – 15	Indicates Hazardous Drinking
16 – 19	Indicates Harmful Drinking
20+	Indicates Possible dependence