SIDCUP MEDICAL CENTRE

Dr Sid Deshmukh MBBS MD DRCOG
Dr Ebenezer Timeyin BM BCh LMSSA LRCP LRCS
Dr Shraddha Karkare MBBS MD MRCOG MRCGP DFSRH
Dr Sonia Khanna MBBS BSc nMRCGP DFSRH
Dr Ravi Muthukaluvan MBBS D.Ortho MRCS nMRCGP
Dr Sugandhi Ramu MBBS MRCGP DGO
Dr Matthew Corbett MBBS MRCGP(2013)
Jillian Kemp Nurse Practitioner
Linda Wilson Nurse Practitioner
Sharon Ciel Nurse Practitioner

Main Surgery
2 Church Avenue, Sidcup, Kent, DA14 6BU
Tel: 020 8302 1114, Fax: 020 8309 6350
Email: sidcupmedical@nhs.net
Branch Surgery
231 Burnt Oak Lane, Sidcup, Kent, DA15 9BQ
Tel: 020 8300 2747, Fax: 020 8302 8326
Branch Surgery
63 Thanet Road, Bexley, Kent, DA5 1AP
Tel: 01322 528221, Fax: 01322 555449

Dear Patient

Thank you for applying to register with our practice. In order that we can process your application, can you please complete the attached forms in as much detail as possible.

Please note that if you are on repeat medication, we require a copy of your repeat slip. If you do not have one, please contact your former G.P. to obtain a copy. This will ensure that we have the correct spelling and dosage of any medication you might be taking.

We also require one proof of personal identity which includes your date of birth. This could be your passport or driving licence. We also require two proofs of residency within our practice area. These proofs should be no more than three months old. Suitable examples are utility bills, bank or mobile phone statements, council tax forms and Benefit Agency letters. Please attach photocopies of these documents to your application form, although we will need sight of the original documents.

If you are unable to produce proofs of residency, you need to contact Bexley Council to request a letter confirming that you are on the electoral roll. If you do not have any bills in your name, we require a handwritten letter from the billpayer (who must already be registered with the practice) confirming this fact and confirming that you are resident at their address.

This surgery offers an online service for our patients where you can book appointments and order your repeat prescriptions online at your convenience. The online registration form is now contained within this registration pack. It can also be obtained from reception or online at http://www.sidcupmedicalcentre.co.uk/

The surgery has an active Patient Participation Group and a Virtual Patient Group, these aim to provide a communication channel between patients and the practice. We are always looking for new members. If you are interested in joining either of these groups please contact Louise at the Surgery.

Welcome to Sidcup Medical Centre.

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

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_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

NHS Family doctor services registration

GMS1

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 ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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 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 CHS list 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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NEW PATIENT QUESTIONNAIRE

It is our policy to offer all new patients a medical check with the nurse. You must book your medical check within 28 days of being accepted by the practice. This is important as the doctors will not be able to see you until you have had this check. If we do not hear from you within 28 days of your application, we will assume that you no longer wish to register with our practice. Please try and answer as many questions as possible. The information you provide will be treated confidentially. While registering a child under 5 years of age, please note that exact dates of immunisation must be entered on this form and the RED BOOK must be submitted. You can collect the RED BOOK from Reception 2 weeks later

Date of application:

MR / MRS / MISS / MS / OTHER (PLEASE SPECIFY):		
SURNAME	**FORENAME(S)**	
PREVIOUS SURNAME(S) (if applicable)		
DATE OF BIRTH	**PLACE OF BIRTH**	
SEX:		
ADDRESS: **FULL POST CODE**		
TEL NO: HOME	**MOBILE**	**WORK**
SINGLE / MARRIED / COHABITING / DIVORCED / WIDOWED / SEPARATED		

HEIGHT:	**CURRENT WEIGHT (IF KNOWN):**

OCCUPATION:

IF YOU ARE HOUSEBOUND AND HAVE A KEYSAFE PLEASE PROVIDE DETAILS;

PREVIOUS ADDRESS:

NAME AND ADDRESS OF PREVIOUS GP:
REASON FOR CHANGING GP:

NEXT OF KIN

MR / MRS / MISS / MS / OTHER (PLEASE SPECIFY):		
SURNAME	FORENAME(S)	
PREVIOUS SURNAME(S) (if applicable)		
DATE OF BIRTH	PLACE OF BIRTH	
SEX:		
ADDRESS:		FULL POST CODE
TEL NO: HOME	MOBILE	WORK

DEPENDANTS:

NAME	AGE	RELATIONSHIP

IMPORTANT

******ARE YOU TAKING ANY MEDICATION?******

**** YES / NO ****

****IF YES, PLEASE ATTACH A COPY OF THE REPEAT MEDICATION SLIP FROM YOUR PREVIOUS DOCTOR OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR APPLICATION FORM****

ARE YOU ALLERGIC OR SENSITIVE TO ANYTHING? YES / NO

IF YES, PLEASE GIVE DETAILS:

PLEASE GIVE DETAILS OF ANY SIGNIFICANT ILLNESSES, MEDICAL PROBLEMS, OPERATIONS OR OTHER HOSPITAL CONTACTS

MEDICAL PROBLEM	DATE FIRST DIAGNOSED
OPERATION	**DATE OF OPERATION**

DO YOUR PARENTS/GRANDPARENTS/BROTHER/SISTER SUFFER FROM ANY CONDITIONS?

MEDICAL CONDITION	RELATIONSHIP TO YOU	AGE AT DIAGNOSIS

SMOKING STATUS

CURRENT SMOKER	□	**HOW MANY PER DAY?**
EX SMOKER	□	**WHICH YEAR DID YOU STOP?**
NEVER SMOKED	□	

(WE OFFER SMOKING CESSATION ADVICE. IF YOU ARE A SMOKER AND WISH TO GIVE UP, PLEASE RING THE SURGERY AND ASK TO BE REFERRED)

ALCOHOL STATUS

NEVER HAD ALCOHOL	□	
CURRENT DRINKER	□	**IF YES, HOW MANY UNITS PER WEEK?** **(1 unit = 1 small glass of wine or half pint of beer or 1 short)**
EX DRINKER	□	**IF YES, DATE STOPPED?**.....

CARERS

ARE YOU A CARER?	**Yes/No**	**Details of person cared for**
DO YOU HAVE A CARER?	**Yes/No**	**Details of your carer**

VACCINATIONS:

DATE OF LAST TETANUS VACCINATION (if known):

DATE OF YOUR POLIO BOOSTER (if known):

FEMALE PATIENTS ONLY:

DATE OF LAST SMEAR TEST: **RESULT:** **RECALL:**

HAVE YOU HAD A HYSTERECTOMY: **Yes/No** **REASON (if known):**

SIGNATURE OF PATIENT	SIGNATURE ON PATIENT'S BEHALF	DATE

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. IT WILL ENABLE THE DOCTOR TO HAVE USEFUL INFORMATION ON YOUR HEALTH BEFORE YOUR FIRST VISIT TO THE SURGERY. Please ring the surgery 4 working days after you have submitted this application. The receptionist will then be able to tell you whether you have been accepted by the practice. Please ring after 11 AM to avoid the busy morning hours.

About Patient Online services

https://www.patient-services.co.uk/

We offer an online service for our patients so you can book your appointments and order your repeat prescriptions online at your convenience.

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**
Once you are registered the practice will give you the information that will enable you to create a username and password.

Online appointment booking
Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don't need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

Request your repeat prescriptions online
Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

Access to your GP record online
Take greater control of your health and wellbeing by being able to view your medication history, allergies and adverse reactions online.

Practice Statement
Your medical information is personal and should not be shared. Each patient is responsible for the security of their own information they see or download. If you choose to share your information with anyone else, this is at your own risk.
Please contact the practice if you would to discuss authorized proxy access.

Patient Online - Patient registration form

If you would like to register for online services please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password.

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

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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

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.	☐

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Passport ☐ Drivers Licence ☐ Other Photo ID_____ ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation

ALCOHOL CONSUMPTION QUESTIONNAIRE – SIDCUP MEDICAL CENTRE

NAME:_____ **DATE OF BIRTH:**_____

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10) ☐
(1) Monthly or less ☐
(2) 2 to 4 times a month ☐
(3) 2 to 3 times a week ☐
(4) 4 or more times a week ☐

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2 ☐
(1) 3 or 4 ☐
(2) 5 or 6 ☐
(3) 7, 8, or 9 ☐
(4) 10 or more ☐

3. How often do you have six or more drinks on one occasion?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never ☐
(1) Less than monthly ☐
(2) Monthly ☐
(3) Weekly ☐
(4) Daily or almost daily ☐

9. Have you or someone else been injured as a result of your drinking?

(0) No ☐
(2) Yes, but not in the last year ☐
(4) Yes, during the last year ☐

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No ☐
(2) Yes, but not in the last year ☐
(4) Yes, during the last year ☐

Add up the points associated with your answers above. A total score of 8 or more indicates harmful drinking behavior. See your doctor.
MY TOTAL SCORE AFTER ADDING ANSWERS TO ALL 10 QUESTIONS IS
_____

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Dear Patient

The Health Service needs to know the ethnic group of patients for the purpose of planning, to ensure all sectors of the community have equal access to the services provided.

Ethnic group describes how you see yourself and is a mixture of culture, religion, skin colour, language and the origins of yourself or your family. It is **not** the same as nationality. The information you provide will be treated in the strictest confidence. It will only be used by National Health Service staff and will not be passed on to other agencies or used for any other reason.

Please indicate the ethnic group to which you feel you belong:-

White & White British	**Mixed**	**Asian & British Asian**
A White British	**D** White & Black Caribbean	**H** Asian Indian
B White Irish	**E** White & Black African	**J** Asian Pakistani
C White Other	**F** White & Asian	**K** Asian Bangladeshi
G Any other mixed Background	**L** Any other Asian Background	

Black & Black British	**Other Ethnic Groups**
M Black Caribbean	**R** Chinese/ British Chinese
N Black African	**S** Any other ethnic group

P Other black background (please write in:_____)

Z If you do not wish to divulge your ethnic details

Please use the relevant codes from above to indicate your ethnic group. _____

LAST NAME	FIRST NAME(S)	DATE OF BIRTH	ETHNIC CODE

PLEASE INDICATE YOUR FIRST LANGUAGE (SPOKEN)

_____

IF REGISTERING A BABY, PLEASE INDICATE WHAT YOUR BABY'S FIRST SPOKEN LANGUAGE WILL BE

_____

SIDCUP MEDICAL CENTRE
CARER
IDENTIFICATION AND CONSENT FORM

Do you look after someone – a relative, friend or neighbour who is ill, frail or disabled and is unable to or has difficulty looking after themselves? Do you give support to someone who has mental health needs or misuses alcohol or drugs?

If you are, that means you are a Carer and by registering that you are a Carer with the Practice it could mean that we are able to offer you more support.

PLEASE COMPLETE THIS FORM AND HAND IT TO RECEPTION, OR POST IT TO US.

YOUR DETAILS:

Surname:..... Forename:.....

Date of Birth: .....

Address:.....

.....

..... Post Code:.....

Home No:..... Mobile No:.....

Email:.....

Relationship to person cared for :.....

I live with the person I care for**:**	**Yes**	☐	**No**	☐
I am their next of kin:	**Yes**	☐	**No**	☐
I am their emergency contact:	**Yes**	☐	**No**	☐
I am the main carer:	**Yes**	☐	**No**	☐

I give consent to being registered as a Carer with this practice**:**

Signed:..... Date:.....

I give permission for my details to be passed to the Carers' Support (Bexley) for advice and support. **Yes** ☐ **No** ☐

Practice Administrative Staff Only:
If the Carer has agreed for the information to be sent to Carers' Support (Bexley) please scan and email to: carerssupport@nhs.net or post to: Carers' Support (Bexley), the Manor House, Grassington Road, Sidcup, Kent, DA14 6BY.

SIDCUP MEDICAL CENTRE
CARER
IDENTIFICATION AND CONSENT FORM

Carer's Name: ……

DETAILS OF PERSON CARED FOR:

Surname:…… Forename:……

Date of Birth: ……

Address:……

……..

……..

Home No:…….. Mobile No:……..

Email:……

I give consent for the above information about me to be recorded on the clinical record of the person who cares for me.

I give consent for the details of my Carer to be held on my medical records.

I also give consent for relevant medical information to be shared with my Carer.

Signed:…….. Date:……