

For office use only:

Date of appointment with Pharmacist if on regular medication:



REGISTRATION FORM

If you are on regular medication you will need to see our Pharmacist before we can issue any prescriptions. This will be arranged on application to join the practice

Full Name _____ Date of Birth _____

Full Address _____

Email Address _____

I confirm I give the surgery permission to use my email address as a form of communication with me Yes /No

Tel No: _____ Occupation _____

Next of Kin and Contact Details _____

PLEASE NOTE

The practice reserves the right to refuse registration of patients for the following reasons;

- Previous breakdown of therapeutic relationship;
- Alleged fraud;
- Violent behaviour or threat of violent behaviour

Your doctor and the team of health professionals caring for you take records about your health and any treatment or care you receive from the NHS. This information will either be written down (manual records) or held on computer (electronic records). These records are then used to guide and manage the care you receive. You may also be receiving care from an organisation outside of the NHS e.g. social services. If so we may need to share information about you so that everyone involved in your care can work together for your benefit. Whenever this is necessary your information will be handled in the strictest of confidence and will be subject to the principles of confidentiality. Please see our privacy notice (available at reception on request) or alternatively it is available on our website www.bellevuegp.com.

CARERS IDENTIFICATION

Carers are people who look after relatives or friends who cannot manage at home without help. This may be because they have a disability/illness or because they are frail.

Do you look after someone? YES /NO

OR

Does someone look after you? YES /NO

PLEASE ENTER THE INFORMATION REQUESTED BELOW

If you are unsure, we have a room with a weighing scale, height measure and BP machine available for you to use.

Please ask the receptionist to direct you.

Weight:

Height:

Blood Pressure:

Do you Smoke: Yes /No

If No have you ever smoked:

How many units of alcohol do you consume per week:

Last Flu Vaccination Date:

Please confirm your first language:.....

Do you require an interpreter for consultations Yes /No

CURRENT MEDICATION

If you are on Regular Medication, we require a list of medications you are taking to add to our GP System. This needs to be an update to date list (within the last 3 months) and can be either:

- 1. GP Repeat Slip
- 2. GP Print out
- 3. Recent Hospital Discharge
- 4. Prison Discharge
- 5. Hospital Letters
- 6. Photos of your medications with Named Labels (one of the above is preferable)

If possible, please provide one of the above when you register with us.

If you are unable to supply us with one of the above, please tick here
(we will need to follow this up with your previous GP)

You will require a telephone review with one of the Practice Pharmacists before you run out of medications. You can request your medication from your previous GP Practice until the registration process is complete.

Reception will book this for you and give you an appointment slip

For our information Pharmacist Appointment booked on

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Choose **ONE** section and then tick **ONE** box to indicate your background:

White		Mixed	
<input type="checkbox"/>	British	<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	Welsh	<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	Irish	<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other white background (please write)	<input type="checkbox"/>	Any other mixed (please write)
Asian or Asian British		Black or Black British	
<input type="checkbox"/>	Indian	<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	African
<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Any other Black background (please write)
<input type="checkbox"/>	Any other Asian background (please write)	Not stated or declined	
Chinese \ Japanese		<input type="checkbox"/>	Declined: Patient chose not to disclose information
<input type="checkbox"/>	Chinese		
<input type="checkbox"/>	Japanese		
<input type="checkbox"/>	Any other (please write)		

Please tick **ONE** of the following statements:

I am ordinarily resident in the UK (Wales) for a settled purpose (work, study) for at least 6months	<input type="checkbox"/>
I have formally applied for asylum in the UK and my application is still under consideration by the home office	<input type="checkbox"/>
I am a refugee who has been given leave to remain in the UK	<input type="checkbox"/>
I am an EEA National (Austria, Belgium, Cyprus, Czech Rep., Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Irish Rep., Italy, Latvia, Lichtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and Switzerland)	<input type="checkbox"/>
I have an emergency problem which requires immediate and necessary treatment (e.g. chest pain that may indicate heart attack) this would NOT include having forgotten medication.	<input type="checkbox"/>
I am not eligible for NHS treatment and request to be seen as a private patient. (£40 charge applicable for 10min consultation, prescriptions are paid for separately)	<input type="checkbox"/>
	<input type="checkbox"/>

I am applying for registration as a patient at this practice and I declare my eligibility as identified above. I understand that if my declaration is later found to be false, I may immediately forfeit my right to treatment at this practice and maybe liable for the cost of treatment.

Signed _____ Date: _____

(If registering a child, signature of parent or guardian)

REGISTRATION OF CHILDREN

Please confirm below that both father and mother have parental rights for the child. If only one parent has parental rights please indicate below:

We confirm that BOTH Father and Mother have parental rights as below

NAME Father

NAME Mother

I confirm that only I have parental rights as below

NAME Relationship

BELLEVUE GROUP PRACTICE Acceptable Behaviour Contract

Patients Name	
Address	
NHS Number	

Responsibility and Rights – A Patient Undertaking

Your Rights	Your Responsibilities
Bellevue Group Practice and their staff owe to me, as a patient, a duty of care and aim to provide services to meet my needs for healthcare and treatment at all times.	I will not behave in any way, which can be considered intimidating, violent or abusive.
Bellevue Group Practice and their staff aim to provide health services that are sympathetic to my individual needs within the resources which the ABUHB/Primary Care Independent Contractor has available.	Violence includes any incident where Bellevue Group Practice and their staff, fellow patients and their carers are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, well being or health of any member of ABUHB staff, Bellevue Group Practice and their staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of NHS property as well as physical acts of violence.
Bellevue Group Practice and their staff are expected to treat me with courtesy and respect	I will treat Bellevue Group Practice and their staff, fellow patients and their carers and visitors politely and with respect at all times.
Bellevue Group Practice and their staff want to deliver appropriate and effective healthcare and treatment to me.	I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on NHS premises.
Bellevue Group Practice and their staff will only restrict or withdraw my rights to care in exceptional circumstances when I have failed to comply with any of my responsibilities in a manner which is deemed acceptable.	I will not to attend the practice already intoxicated; I understand that I will not be seen if I do so, unless it is a clinical emergency.
	I accept and understand that Bellevue Group Practice is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of the Bellevue Group Practice team has to jeopardise their safety in providing me with care.

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient and the UNACCEPTABLE BEHAVIOUR, VIOLENCE AND AGGRESSION POLICY –then this can result in the withdrawal of my rights as a patient and I can lose my right to receive mainstream NHS Primary Care Services.

(Unacceptable behaviour, Violence and Aggression Policy - Please see the website or if you have no internet access contact the surgery for a printed copy)

Signature of patient	
Print Name (Block Capitals)	
Date	
Signature of Bellevue Group Practice (Print name and Block Capitals)	
Date	



Cofrestru gyda gwasanaethau meddyg teulu

Family doctor services registration

GMS1W



Manylion y claf

Patient's details

Cwblhewch y rhan hon mewn PRIF LYTHRENNAU a thiciwch y blychau lle bo'n briodol
Please complete in BLOCK CAPITALS and tick as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Cyfenw Surname
Dyddiad geni Date of birth				Enwau cyntaf Forenames
Rhif GIG	Cyfenw(au) blaenorol Previous surname/s			Adnabyddir fel Known Name
NHS No.	Tref a gwlad eich geni Town and country of birth			Enw'ch mam cyn priodi Mothers Maiden Name
<input type="checkbox"/> Gwryw Male <input type="checkbox"/> Benyw Female				
Cyfeiriad presennol Current address				

Cod Post Postcode	Rhif ffôn Telephone number
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Helpwch ni i olrhain eich cofnodion meddygol blaenorol drwy ddarparu'r wybodaeth ganlynol

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

Eich cyfeiriad blaenorol yn y DU, pan oeddech wedi'ch cofrestru gyda meddygfa meddyg teulu
Your previous address in the UK, whilst registered with a GP surgery

Enw'ch meddyg blaenorol pan oeddech yn y cyfeiriad hwnnw
Name of previous doctor while at that address

Cyfeiriad eich meddyg blaenorol Address of previous doctor
Cod Post Postcode

Os ydych o dramor

If you are from abroad

Eich cyfeiriad cyntaf yn y DU lle roeddech wedi cofrestru gyda meddyg teulu
Your first UK address where registered with a GP

Ydych chi erioed wedi cofrestru â Meddyg Teulu y GIG yn y DU?

Have you ever registered with a NHS GP in the UK?

Ydw
Yes Nac Ydw
No

Os oeddech yn arfer byw yn y DU, dyddiad gadael
If previously resident in the UK, date of leaving

Y dyddiad y daethoch gyntaf i fyw yn y DU
Date you first came to live in UK

Ydych chi erioed wedi gwasanaethu fel aelod o luoedd arfog ei mawrhydi?

Have you ever served in HM Armed Forces?

Ydw
Yes Nac Ydw
No

Os ydych yn dod yn ôl o'r Lluoedd Arfog

If you are returning from the Armed Forces

Cyfeiriad cyn ymrestru
Address before enlisting

Dyddiad ymrestru Enlistment date	Dyddiad gadael Discharge date	Rhif gwasanaeth neu bersonél, Rhif BFPO Service or Personnel number, BFPO Number
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Os oes angen i'ch meddyg weinyddu meddyginiaeth a theclynnau meddygol*

If you need your doctor to dispense medicines and appliances*

* Nid oes awdurdod gan bob meddyg i weinyddu meddyginiaeth
* Not all doctors are authorised to dispense medicines

Rwy'n byw mwy na milltir mewn llinell syth oddi wrth y fferylllydd agosaf
I live more than 1 mile in a straight line from the nearest chemist

Byddai'n anodd dros ben i mi gael gafael arnynt gan fferylllydd
I would have serious difficulty in getting them from a chemist

Eithrio o Gofnod Iechyd Unigol y GIG

Rwy'n dymuno eithrio o'r Cofnod Iechyd Unigol ac atal staff meddygol sy'n darparu gofal brys rhag gweld fy ngwybodaeth feddygol allweddol. Rwyf wedi derbyn digon o wybodaeth i wneud dewis gwybodus ac rwy'n cydnabod y gallai eithrio fel hyn amharu ar fy ngofal iechyd. Mae rhagor o wybodaeth ar gael yn www.wales.nhs.uk/cofnodiechydunigol neu drwy ffonio Galw Iechyd Cymru ar 0845 46 47

NHS Individual Health Record Opt Out

I want to opt out of the Individual Health Record and prevent emergency care medical staff being able to access my key medical information. I have received enough information to make an informed decision and I acknowledge that opting out could be detrimental to my healthcare. Further information is available by visiting www.wales.nhs.uk/individualhealthrecord or by calling NHS Direct on 0845 46 47

Llofnod y claf
Signature of patient Llofnod ar ran y claf
Signature on behalf of patient

Dyddiad
Date

Gweler trosodd ynghylch rhoi organau
Please see overleaf re: Organ donation

Cofrestru fel Rhoddwr Organau gyda'r GIG NHS Organ Donor registration

I fod yn rhoddwr organau yng Nghymru gallwch gofrestru penderfyniad ar Gofrestr Rhoddwyr Organau'r GIG drwy dicio'r blychau perthnasol isod, neu ddewis gwneud dim. Drwy wneud dim, cymerir yn ganiataol nad oes gennych unrhyw wrthwynebiad i roi organau, ac ystyrir hynny'n gydsyniad tybiedig.

Os nad ydych am fod yn rhoddwr organau gallwch gofrestru'r penderfyniad hwnnw ar y Gofrestr Rhoddwyr Organau. Gallwch wneud hyn drwy fynd i'r wefan neu ffonio'r rhif ffôn isod. Nid oes modd cynnig y cyfleuster i optio allan drwy'r ffurflen hon ar hyn o bryd.

To become an organ donor in Wales you can register a decision on the NHS Organ Donor Register by ticking the relevant boxes below, or choose to do nothing. By doing nothing you will be considered as having no objection to organ donation and your consent may be deemed to be given.

If you do not want to become an organ donor you can register this decision on the Organ Donor Register. You can do this by going to the website or calling the phone number below. It is not possible to offer the facility to opt out via this form at the present time.

Unrhyw un o'm horganau a'm meinwe neu
Any of my organs and tissue or

Arennau
Kidneys

Calon
Heart

Afu/lau
Liver

Cornbilennau
Corneas

Ysgyfaint
Lungs

Pancreas
Pancreas

Unrhyw ran o'm corff
Any part of my body

Llofnod yn cadarnhau fy mod yn cytuno i roi organau/meinwe
Signature confirming my agreement to organ/tissue donation

Dyddiad _____ / _____ / _____
Date

I gael rhagor o wybodaeth, gofynnwch wrth y dderbynfa am daflen wybodaeth neu ewch i'r wefan www.rhoiorganau.org neu ffoniwch 0300 123 23 23
For more information, please ask at the reception for an information leaflet or visit the website www.organdonationwales.org or call 0300 123 23 23

Cofrestru fel Rhoddwr Gwaed gyda'r GIG NHS Blood Donor registration

Hoffwn ymuno â Chofrestr Rhoi Gwaed y GIG fel rhywun y gellir cysylltu ag ef a byddwn yn barod i roi gwaed. Ticiwch yma os ydych wedi rhoi gwaed yn y 3 blynedd diwethaf

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

Llofnod yn cadarnhau fy nghaniatâd i gael fy nghynnwys ar Gofrestr Rhoi Gwaed y GIG
Signature confirming consent to inclusion on the NHS Blood Donor Register

Dyddiad _____ / _____ / _____
Date

I gael rhagor o wybodaeth, gofynnwch am y daflen ar ymuno â Chofrestr Rhoi Gwaed y GIG. Y cyfeiriad gorau i anfon gwybodaeth iddo yw: (dim ond os yw'n wahanol i'r uchod, ee eich gweithle)
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)

Cod Post Postcode: _____

I'w gwblhau gan y meddyg

To be completed by the doctor

Enw'r Meddyg
Doctors Name

Cod HB
HB Code

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol
I have accepted this patient for general medical services

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol ar ran y meddyg isod sy'n aelod o'r feddygfa hon
I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Enw'r Meddyg, os yw'n wahanol i'r uchod
Doctors Name, if different from above

Cod HB
HB Code

Byddaf yn gweinyddu meddyginiaethau/teclynnau meddygol i'r claf hwn yn amodol ar Gymeradwyaeth yr Awdurdod Iechyd
I will dispense medicines/appliances to this patient subject to Health Board Approval

Rwyf yn datgan bod yr wybodaeth hon, hyd y gwn i, yn gywir.
I declare to the best of my belief this information is correct.

Llofnod Awdurdodedig
Authorised Signature

Stamp y Feddygfa
Practice Stamp

Enw
Name

Dyddiad _____ / _____ / _____
Date