For office use only:
Date of appointment with Pharmacist if on regular medication:

# BELLEVUE GROUP PRACTICE

## 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 _____

**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 CONFIRM THE FOLLOWING INFORMATION**:

Weight:

Height:

Do you Smoke: Yes/No

If No have you ever smoked:

How many units of alcohol do you consume per week:

**PLEASE TAKE YOUR BLOOD PRESSURE ON OUR SELF SERVICE BLOOD PRESSURE MACHINE IN RECEPTION AND CONFIRM THE READING BELOW:**

Blood Pressure:

Please confirm your first language:.....

Do you require an interpreter for consultations Yes/No

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** | |
| ☐ | British | ☐ | White and Black Caribbean |
| ☐ | Welsh | ☐ | White and Black African |
| ☐ | Irish | ☐ | White and Asian |
| ☐ | Any other white background (please write) | ☐ | Any other mixed (please write) |
| **Asian or Asian British** | | **Black or Black British** | |
| ☐ | Indian | ☐ | Caribbean |
| ☐ | Pakistani | ☐ | African |
| ☐ | Bangladeshi | ☐ | Any other Black background (please write) |
| ☐ | Any other Asian background (please write) | **Not stated or declined** | |
| **Chinese\ Japanese** | | ☐ | Declined: Patient chose not to disclose information |
| ☐ | Chinese | | |
| ☐ | Japanese | | |
| ☐ | 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 | ☐ |
| I have formally applied for asylum in the UK and my application is still under consideration by the home office | ☐ |
| I am a refugee who has been given leave to remain in the UK | ☐ |
| 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) | ☐ |
| 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. | ☐ |
| 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) | ☐ |
| | |

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 .....

CURRENT MEDICATION

Please list all of your current medication:

**IF YOU ARE ON REGULAR MEDICATION YOU MUST HAVE AN APPOINTMENT WITH THE PRACTICE PHARMACIST ABOUT A WEEK AFTER REGISTERING. PLEASE ENSURE THIS APPOINTMENT IS MADE FOR YOU WHEN YOU HAND IN YOUR FORMS AT RECEPTION**

.....

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# 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 ☑

☐ Mr Mr ☐ Mrs Mrs ☐ Mis Miss ☐ Ms Ms

Cyfenw
Surname

Dyddiad geni
Date of birth

Enwau cyntaf
Forenames

Rhif GIG
NHS No.

Cyfenw(au) blaenorol
Previous surname/s

Adnabyddir fel
Known Name

☐ Gwryw Male ☐ Benyw Female

Tref a gwlad eich geni
Town and country of birth

Enw'ch mam cyn priodi
Mothers Maiden Name

Cyfeiriad presennol
Current address

Cod Post
Postcode

Rhif ffôn
Telephone number

## 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

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

## 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

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

## 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 fferyllydd 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 fferyllydd
I would have serious difficulty in getting them from a chemist

☐ **Eithrio o Gofnod lechyd Unigol y GIG**

Rwy'n dymuno eithrio o'r Cofnod lechyd 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 gyda gwasanaethau meddyg teulu
# Family doctor services registration

GMS1W

## 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