

GP Direct registration checklist

1) Do you reside within our catchment area?

Please check if you reside within our catchment area before completing the forms. You can check online by going to our website www.gpdirect.co.uk and clicking on the **Register** tab (www.gpdirect.co.uk/register). Alternatively you can provide one of our receptionists with your postcode and they can check this for you.

However for postcodes beginning with **HA1** or **HA2** you do not need to check as these are always within our area.

2) Completing your registration form

Please complete the mauve coloured GMS1 form, please ensure each section is completed to try and ensure that your registration is processed smoothly. The checklist is below.

a) GMS1 form check list:

- ☐ Title
- ☐ Surname
- ☐ First name
- ☐ Previous Surname **if** there has been a surname change
- ☐ Gender
- ☐ Country and Town of Birth
- ☐ Address
- ☐ Phone Number
- ☐ Previous GP **if** you have been registered in the NHS previously
- ☐ Previous address **unless** this is the first address you are using in the NHS
- ☐ When you arrived to the UK, if not born in the UK
- ☐ GMS1 form DATED and SIGNED?
- ☐ Please ensure you complete the pre-registration form in full

b) Alcohol Screening Questionnaire: If you are aged 16 or over please complete the Alcohol Screening Questionnaire. If you are teetotaler please tick this box on the form.

c) Consent to Contact you: Please tell us how you would like us to contact you.

d) Tuberculosis (TB) Screening Questionnaire

e) Summary Care Record

3) Proof of ID and/or address

- Evidence of your ID, preferably in the form of visual ID such as a passport or driving licence. If you do not have either of these please try and bring any other official visual ID or a birth certificate
- Proof of address, one of the following: Council Tax bill, tenancy agreement or a utility bill (gas, electric, water bill or home phone bill), bank or credit card statement or a TV license dated within the last three months.

The mauve coloured GMS1 form and pre-registration form must be completed in full and brought to either of our surgeries during their opening hours to submit your registration. The opening hours and addresses are on the reverse of this page. The person requiring registration must attend in person for identification and consent purposes unless they are aged 15 or under in which case the person with parental responsibility can submit the registration form on their behalf along with the necessary identification documents. Please allow two working days for the registration to be completed.

Eligibility to register for primary care services (i.e. registering with a GP Practice) does not necessarily entitle you to secondary care services (i.e. services at hospital). Hospitals have their own guidance on eligibility for NHS care therefore you may be asked to provide them with additional evidence.

Opening hours

GP Direct operates from two sites. However we operate a single switchboard.
This is open from **8am to 6.30pm Monday to Friday.**

Welbeck Road

Day	Time
Monday	08:00am to 08:00pm
Tuesday	08:00am to 06:30pm
Wednesday	08:00am to 08:00pm
Thursday	08:00am to 06:30pm
Friday	08:00am to 06:30pm
Saturday	09:00am to 12:00pm
Sunday	CLOSED

Eastcote Lane

(Closed from 1.00pm to 2.00pm for lunch everyday)

Day	Time
Monday	08:30am to 06:30pm
Tuesday	08:30am to 06:30pm
Wednesday	08:30am to 06:30pm
Thursday	08:30am to 06:30pm
Friday	08:30am to 06:30pm
Saturday	CLOSED
Sunday	CLOSED

The Surgery is closed on all public holidays. Correct as of July 2020.

Our addresses:

Welbeck Road Surgery

3-7 Welbeck Road
Harrow
Middx
HA2 0RQ

Eastcote Lane Surgery

32a Eastcote Lane
South Harrow
Middx
HA2 8BS

Contact Information:

Phone Number:

0208 515 9300

Email:

gpdirect@nhs.net

Website:

www.gpdirect.co.uk

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 ____/____/____

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:

HA use only

Patient registered for

☐ GMS

☐ CHS

☐ Dispensing

☐ Rural Practice

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

SUPPLEMENTARY QUESTIONS

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:

- a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice
- b) ☐ 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
- c) ☐ 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:			

Complete this section if you live in another EEA 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: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p>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.</p>	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

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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

This information is required for your medical records and is strictly confidential.

Have you ever been registered with a GP in the UK before? Yes ☐ No ☐

Have you ever been registered at GP Direct before, even as a temporary, immediate necessary or private patient? Yes ☐ No ☐

1) PERSONAL DETAILS (ALL FIELDS MARKED WITH * ARE MANDATORY AND MUST BE COMPLETED)

Title*	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Mx <input type="checkbox"/> Dr <input type="checkbox"/>	Address*	
Date of Birth*	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>		
Surname*	<input type="text"/>		
First Name*	<input type="text"/>		
Middle Name	<input type="text"/>		
Previous Surname	<input type="text"/>	Post Code*	<input type="text"/>
Landline Number	<input type="text"/>	Country of Birth*	<input type="text"/>
Mobile Number	<input type="text"/>	Town of Birth*	<input type="text"/>
Do you consent for us to send you appointment reminders and other health related reminders via SMS* Yes <input type="checkbox"/> No <input type="checkbox"/>		Ethnicity	<input type="text"/>
Email Address	<input type="text"/>	Religion	<input type="text"/>
Do you have any special communication needs? Yes <input type="checkbox"/> No <input type="checkbox"/>		Occupation	<input type="text"/>
If yes, please specify	<input type="text"/>	Relationship Status	<input type="text"/>
		First Language	<input type="text"/>
Can you communicate in English	Yes <input type="checkbox"/> No <input type="checkbox"/>		

2) NEXT OF KIN DETAILS Please provide details of your next of kin

Name	<input type="text"/>	How are they related to you?	<input type="text"/>
Phone Number	<input type="text"/>	<input type="checkbox"/> I acknowledge that it is my responsibility to update this information if it changes	
Are you happy for us to contact your next of kin in an emergency? Yes <input type="checkbox"/> No <input type="checkbox"/>			

3) FAMILY HISTORY Have any of your relations had any of the following illnesses or diseases?

Diabetes	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
Cancer	<input type="checkbox"/> Relation(s)	<input type="text"/>	Please specify	<input type="text"/>
Stroke	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
Mental Illness	<input type="checkbox"/> Relation(s)	<input type="text"/>	Please specify	<input type="text"/>
Asthma	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
Epilepsy	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
High Blood Pressure	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
Eczema	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
Heart Attack / Heart Disease	<input type="checkbox"/> Relation(s)	<input type="text"/>	Further Information	<input type="text"/>
	Age Diagnosed	<input type="text"/>		

4.0) YOUR HEALTH - GENERAL HEALTH

Height

Weight

How much exercise do you take?

☐ 0 time week ☐ 1 times week ☐ 2 times week ☐ 3+ times week

Do you have any current or past medical conditions that we should be aware of ? Yes ☐ No ☐ If yes please state below

Is there anything special or unusual about your diet? Yes ☐ No ☐

Do you receive any care from Social Services? Yes ☐ No ☐ If yes please state

Do you have any disabilities? Yes ☐ No ☐ If yes please state

Have you ever misused drugs or solvents? Yes ☐ No ☐ If yes please state

4.1) YOUR HEALTH - SMOKING AND ALCOHOL

SMOKING

Do you currently smoke? Yes ☐ No ☐

Cigarettes ☐ a day

Cigars ☐ a day

Pipe ☐ ounces a day

Water Pipe (Shisha) ☐ a day

Electronic Cigarettes / Vape ☐ a day

If you are an ex-smoker when did you stop
(please state the year & quantity)?

ALCOHOL

What is your average weekly intake of alcohol in units?

units a week

(1 unit = half a pint of beer or cider, one glass of wine or sherry or
1 measure of whisky/rum/gin/vodka)

If you do not drink alcohol at all, i.e. are a teetotaler
please tick here ☐

**If you are not a teetotaler and aged 16 or over please
complete the Alcohol FAST questionnaire at the
end of this health questionnaire.**

4.2) YOUR HEALTH - MEDICATION AND ALLERGIES

ALLERGIES

Do you have any Drug Allergies? Yes ☐ No ☐ If yes please state below

What are you allergic to

What happens?

Do you have any Non-Drug Allergies? Yes ☐ No ☐ If yes please state below

What are you allergic to

What happens?

MEDICATION

Do you take any regular medication? Yes ☐ No ☐ If yes please provide name of medication(s) & dosage below

4.3) YOUR HEALTH - SCREENING

To help ensure you receive the correct health screening invites, please confirm your assigned gender at birth? Male ☐ Female ☐
For more information about screening on the NHS please visit: <https://www.gov.uk/guidance/nhs-population-screening-explained>

CERVICAL SCREENING - ONLY ANSWER IF APPLICABLE TO YOU

Have you ever had your cervical screening test done in the UK? Yes ☐ No ☐ If yes please give details below:

Date of last screening Where was it done?

What was the result of the screening?

Have you had a total hysterectomy? Yes ☐ No ☐ Date of total hysterectomy

BREAST SCREENING - ONLY ANSWER IF APPLICABLE TO YOU

Have you ever had a mammogram or other breast cancer screening? Yes ☐ No ☐ If yes please state what below:

Date of last screening

4.4) YOUR HEALTH - CONTRACEPTION

CONTRACEPTION - ONLY ANSWER IF APPLICABLE TO YOU

Do you use any form of contraception? Yes ☐ No ☐ If yes please give details below:

Please tick if you have: ☐ Intrauterine contraceptive device (coil) or ☐ Nexplanon (contraceptive implant)

When was it fitted

**Contraceptive IUDs (Coils) and Implants (such as Nexplanon) require changing at specific intervals, these may vary between 3 to 10 years.
Please ensure you request an appointment to have this done if it is due, if you are unsure please request a telephone consultation with a GP.**

4.5) YOUR HEALTH - PREGNANCY

PREGNANCY - ONLY ANSWER IF APPLICABLE TO YOU

Have you ever been pregnant? Yes ☐ No ☐ If yes please give details below:

Date	Pregnancy Outcome	Complications of Pregnancy	Problems of delivery	Birth Weight
DD/MM/YY				
DD/MM/YY				
DD/MM/YY				
DD/MM/YY				
DD/MM/YY				

GP Direct has a “zero tolerance” policy. This means that we will immediately remove any patient (and their family if appropriate) if they are seen to be rude, aggressive or pose a danger to any one of our staff.

Fast Alcohol Screening Test (FAST) and Alcohol Users Disorders Identification Test (AUDIT)

Name (please print): _____

Date of Birth: _____

☐

Male

☐

Female

Are you a teetotaler, i.e. do not drink alcohol at all? Yes ☐ No ☐



Questions		Scoring System					Your Score
		0	1	2	3	4	
1	How often do you have 8 (men) or 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
2	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
3	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4	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	
Please add your score for questions 1 – 4							
If your score so far comes to 3 or more please continue with the questionnaire, if it is 2 or less please stop							
5	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2-3 times per week	4+ times per week	
6	How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
7	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
10	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	
Please add your score for questions 1 – 10							

FAST (first 4 questions) = **2 or less** no need to continue, **3 or more** you will need to complete all 10 questions

AUDIT (all 10 questions): **0-7** = sensible **8-15** = Hazardous **16-19** = Harmful **20+** = Possible Dependence

Consent to Contact You

Don't miss out - tell us if we can contact you

In order for us to continue contacting you about services or publications related to health promotion we need your consent.

Please read the options below and select the option that best suits your preference.

We will continue to contact you for specific health related matters regardless of your choice below, for example appointment confirmation reminders and invitations for health checks.

Full Name

Date of Birth

DD

MM

YYYY

PLEASE PICK ONE OF THE OPTIONS BELOW

☐ Option 1 **YES**, I consent to receiving health related updates (including the practice newsletter/brochure, medical research invitations relevant to me and information about health promotion events or campaigns) from the practice via SMS/Letter/Email/Phone Calls.

No need to answer question 2.

☐ Option 2 **NO**, I do not consent to receiving health related updates (including the practice newsletter/brochure, medical research invitations relevant to me and information about health promotion events or campaigns) from the practice via SMS/Letter/Email/Phone Calls.

No need to answer question 2.

☐ Option 3, I would like to specify exactly which types of health promotion communication I receive from the practice and the method in which they are sent to me. If you select this option we will go through the specific options in the following question.

Go to question 2.

2. Specific consent preferences

ONLY ANSWER IF YOU SELECTED OPTION 3

Please specify which types of health promotion you consent to us to contact you about and which methods of communication you consent to the practice using.

	SMS	Email	Letter	Phone Call	Don't Contact
Newsletter and brochure from the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient research study invitations and information from the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion events or campaigns (e.g. open days, disease awareness) from the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You are free to change your decision at any time by informing our GP practice.

Information for new patients: about your Summary Care Record

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 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 records. 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 state your decision 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.
- **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 medication, allergies and adverse reactions.

You are free to change your decision at any time by informing our GP practice.

Having read the above information regarding your choices, please choose one of the options below

Yes - I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ 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).

Name	<input type="text"/>				
Date of Birth	<input type="text" value="DD"/>	<input type="text" value="MM"/>	<input type="text" value="YYYY"/>	NHS Number	<input type="text"/>
Address	<input type="text"/>				
Signature	<input type="text"/>			Date	<input type="text" value="DD"/> <input type="text" value="MM"/> <input type="text" value="YYYY"/>

If you are filling out this form on behalf of another person, please ensure that you fill out their details: you sign the form above and provide details below:

Name

Please tick one: ☐ Parent ☐ Legal Guardian ☐ Lasting power of attorney for health and welfare

Tuberculosis (TB) Screening Questionnaire

In an effort to detect latent TB (this is where you may carry TB but not be experiencing any symptoms) we recommend that patients complete this short questionnaire to find out if you are eligible for a free TB screening blood test

Name: Date of Birth

1) Are you aged between 16-35 years old?

☐ Yes. Continue to next question

☐ No. No need to continue

2) Did you enter the UK within the last 5 years?

☐ Yes. Continue to next question

☐ No. No need to continue

3) Were you born or spent 6 months or more in any of the countries below ?

☐ Yes. Continue to next question

☐ No. No need to continue

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Afghanistan | <input type="checkbox"/> Djibouti | <input type="checkbox"/> Madagascar | <input type="checkbox"/> Rwanda |
| <input type="checkbox"/> Angola | <input type="checkbox"/> Equatorial Guinea | <input type="checkbox"/> Malawi | <input type="checkbox"/> Sao Tome and Principe |
| <input type="checkbox"/> Bangladesh | <input type="checkbox"/> Eritrea | <input type="checkbox"/> Mali | <input type="checkbox"/> Senegal |
| <input type="checkbox"/> Benin | <input type="checkbox"/> Ethiopia | <input type="checkbox"/> Marshall Islands | <input type="checkbox"/> Seychelles |
| <input type="checkbox"/> Bhutan | <input type="checkbox"/> Gabon | <input type="checkbox"/> Mauritania | <input type="checkbox"/> Sierra Leone |
| <input type="checkbox"/> Botswana | <input type="checkbox"/> Gambia | <input type="checkbox"/> Mauritius | <input type="checkbox"/> Somalia |
| <input type="checkbox"/> Burkina Faso | <input type="checkbox"/> Ghana | <input type="checkbox"/> Micronesia | <input type="checkbox"/> South Africa |
| <input type="checkbox"/> Burundi | <input type="checkbox"/> Greenland | <input type="checkbox"/> Mongolia | <input type="checkbox"/> South Sudan |
| <input type="checkbox"/> Cote d'Ivoire | <input type="checkbox"/> Guinea | <input type="checkbox"/> Mozambique | <input type="checkbox"/> Swaziland |
| <input type="checkbox"/> Cabo Verde | <input type="checkbox"/> Guinea-Bissau | <input type="checkbox"/> Myanmar | <input type="checkbox"/> Timor-Leste |
| <input type="checkbox"/> Cameroon | <input type="checkbox"/> Haiti | <input type="checkbox"/> Namibia | <input type="checkbox"/> Togo |
| <input type="checkbox"/> Central African Republic | <input type="checkbox"/> India | <input type="checkbox"/> Nepal | <input type="checkbox"/> Uganda |
| <input type="checkbox"/> Chad | <input type="checkbox"/> Indonesia | <input type="checkbox"/> Niger | <input type="checkbox"/> Tanzania |
| <input type="checkbox"/> Comoros | <input type="checkbox"/> Kenya | <input type="checkbox"/> Nigeria | <input type="checkbox"/> Zambia |
| <input type="checkbox"/> Congo | <input type="checkbox"/> Kiribati | <input type="checkbox"/> Pakistan | <input type="checkbox"/> Zimbabwe |
| <input type="checkbox"/> DRP Korea | <input type="checkbox"/> Laos PDR | <input type="checkbox"/> Papua New Guinea | |
| <input type="checkbox"/> DR Congo | <input type="checkbox"/> Lesotho | <input type="checkbox"/> Philippines | |
| | <input type="checkbox"/> Liberia | <input type="checkbox"/> Republic of Moldova | |

4) Any history of TB either treated or untreated?

☐ Yes. No need to continue

☐ No. Continue to next question

5) Have you been screened for TB in the UK before?

☐ Yes. You are not eligible

☐ No. You are eligible

If you have answered all green above you are eligible for a free TB screening blood test.
Please request a TB screening blood test at reception.



Do you provide care for someone?

Dear Patient,

Do you look after someone who is ill, frail or mentally ill? If so, you are a carer. We are interested in identifying carers, especially those people who may be caring without help or support. We know that carers are often “hidden” looking after a family member or helping a friend or neighbour with day to day tasks. These people may not see themselves as a carer.

We feel that caring for someone is an important and valuable role in the community, which is often a 24 hour job that can be very demanding and isolating for the carer. We further believe carers should receive appropriate support by way of access to accurate information on a range of topics such as entitlement to benefits and respite care and, not least, a listening ear when things get too much.

As a carer, you are also entitled to have your needs assessed by Adult Care services. A Carer’s Assessment is a chance to talk about your needs as a carer and the possible ways help could be given. It also looks at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

If you are a carer, this is an opportunity to let the Practice know so that we can update our records and pass on your details to Carers Support Harrow who can provide relevant information and advice, local support and a telephone helpline.

Please complete the attached sheet only if you are a carer and return it to the Surgery.

We look forward to hearing from you.

Yours sincerely,

From the partners at GP Direct

Carers Identification and Referral Form

This form is for use by GP Surgeries to refer carers to Harrow Carers for support.									
Referrer's Details									
Name of Referrer:									
Contact Telephone No:									
Surgery Name:									
Carer's Details									
Name of Carer:									
Contact Telephone No:									
Date of Birth:									
Address:									
Support needs/ Diagnosis:									
Type of service:	Face-to-Face	<input type="checkbox"/>	Phone	<input type="checkbox"/>	Email	<input type="checkbox"/>			
Additional Information: (how you think we can help the carer)									
Cared For/Dependant's Details									
Relationship to carer:									
Name:									
Support needs/ Diagnosis:									
Support offered at Harrow Carers									
Health & Wellbeing Workshops	<input type="checkbox"/>	Low Intensity IAPT <i>e.g. Stress Management, Mindfulness, Sleep Management, Pain Management</i>	<input type="checkbox"/>	Benefits and Welfare Advice / Financial Advice	<input type="checkbox"/>	Home Care/Respite/ Sitting Service/ Live-in Packages	<input type="checkbox"/>	Legal Information and Advice <i>e.g. Carers Rights Awareness</i>	<input type="checkbox"/>
Activities <i>e.g. Yoga, Massage</i>	<input type="checkbox"/>	Condition Specific Support <i>e.g. Dementia, Depression, Anxiety, Psychosis etc...</i>	<input type="checkbox"/>	Training <i>e.g. First Aid, Manual Handling</i>	<input type="checkbox"/>	Reducing Isolation & Social support <i>e.g. Carer-led support groups, drop-ins, monthly outings etc...</i>	<input type="checkbox"/>	Counselling	<input type="checkbox"/>
Contact Consent									
I have obtained permission from the carer to pass their details to Harrow Carers (please tick)					<input type="checkbox"/>	Date			

Essential Apps & Websites



Klinik Access

Klinik Access is available online 24/7 and allows you to submit a request for an appointment or to send through other enquires without needing to call the practice. Klinik Access can be accessed via a smartphone, tablet or PC via the link on our website. If, however, you do not have access to the internet or would prefer to speak to someone, you can continue to call the practice. The receptionists will also utilise the Klinik software to better understand your issue in order to direct it to the most appropriate person within the practice.

www.gpdirect.co.uk



NHS App

Owned and run by the NHS, the NHS App is a simple and secure way to access a range of NHS services on your smartphone or tablet. Request a repeat prescription and choose a pharmacy for your prescriptions to be sent to. Book and cancel appointments, see details of your upcoming and past appointments. Search trusted NHS information and advice on hundreds of conditions and treatments. Securely access your GP medical record. Choose to donate some or all of your organs and check your registered decision and more.

www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/



Patient Access

Patient Access connects you to healthcare services when you need them most. Book appointments, order repeat prescriptions, explore your local pharmacy services. View your medical record, including test results, immunisations and allergies. Securely share your medical record with healthcare professionals of your choosing, without the need to contact your practice and message your GP directly from within Patient Access at home or on the move.

www.patientaccess.com/



eRedbook

The eRedbook mobile app is a personal child health record that has been co-designed with parents and carers. Once you have registered you'll receive NHS.UK articles that are relevant to the age of your child, or your stage of pregnancy. You can receive copies of your child's health records. eRedbook reminds you of upcoming health reviews, screening tests and immunisations. You can record notes, track the growth of your child, and record important developmental milestones.

<https://www.eredbook.org.uk/>



Mjog Messenger

Mjog Messenger is a free app that connects patients to their doctor's surgery for easy, secure, and confidential communication. Take control of your health. Download Mjog Messenger now to get: Automatic appointment reminders One-click appointment cancellation & Prescription notifications.

<https://www.mjog.com/products/mjog-smart/>

