Grŵp Meddygol Ystwyth
Medical Group

www.ystwythmedicalgroup.co.uk

Parc y Llyn
Aberystwyth
Ceredigion
SY23 3TL
01970 613500
contact.w92025@wales.nhs.uk

Welcome to Ystwyth Medical Group

You will need to upload a digital picture of your signature to these forms.
You can do this by saving a picture of your signature and then adding the picture to the form.

Once you have completed these forms, please email them to registrations.w92025@wales.nhs.uk

- **We may have to ask you for proof of address**. We will contact you if we require proof of address.
- **If you are on any repeat medication**, we will need to have received your medical history from your previous GP before we can issue more. You can help speed this by sending the white repeat slip in with your registration pack.
- **If you are a foreign national**, please ensure you complete the date you first came to UK and the GP you have previously registered with. If you are registering with a GP in the UK for the first time you need a valid visa (work, student) and have paid the 'Immigration Health Surcharge' (IHS). Please send us a copy of your visa and proof that you have paid the 'Immigration Health Surcharge' (IHS).

Please allow up to 2 working days for your registration to be processed.

Thank you.

General Practitioner Partners
Dr Steffi Grahl, Dr Ahmed Ellaban
General Practitioners
Dr Gail S Davies, Dr Sarah Wright, Dr Nicholas Cooper, Dr Andrew Bates, Dr Kate Santer, Dr Natalie Harper

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 lechyd 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

☐ Ticiwch y blwch yma os hoffech chi dderbyn gohebiaeth oddi wrthym yn y Gymraeg
Please tick this box if you wish to receive correspondence from us in Welsh

☐ 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

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

Enw
Name

Dyddiad _____/_____/_____
Date

Stamp y Feddygfa
Practice Stamp

Version 052021.01 Product Code: **GMS1W**

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Practice/Patient Contract

At Ystwyth Medical Group, we try to provide optimal care for our patients. This document details how we wish to work together with our patients to provide this. Please read and sign this document.

Opening hours:
We are open from 8 a.m. until 6.30 p.m. Monday to Friday, excluding bank holidays. The Out-of-hours Service can be contacted by ringing 111.

Contact:
It is important that you ensure your contact details are up-to-date at all times. You can update your details via the website or using a form from reception. You can give us permission to contact you with information or reminders via SMS text and also give a third party permission to speak on your behalf and/or collect documents for you.

Appointments:
Appointments may be made with the clinicians in advance, but there are some urgent appointments available "on the day". If you are acutely unwell, we will always try to fit you in, but it may not be with the practitioner of your choice. When you ring, the receptionists will ask you for a brief description of the problem so that they can direct you to the correct clinic.
You may book for specific clinics (e.g. phlebotomy, asthma, diabetes) in advance. There may be a delay in booking routine appointments for some clinics or practitioners when there is a heavy demand.
All the GPs, practitioners and pharmacists provide telephone consultations. Many patients find these more convenient than face-to-face consultation, particularly for follow-up. Please note that, because of workload, we cannot promise to phone at a specific time.
A number of appointments are available via the NHS Wales App, details can be found in your registration pack.
eConsult can be used to request routine advice from the doctor, obtain self help information, or for administrative requests, such as sick notes or letters. The link is on our website.

Cancelling appointments:
Please tell us as soon as possible if you need to cancel an appointment so that another patient can use it.

Late attendance:
Please ring us if you are likely to be late so that we can try to accommodate you. If patients arrive late it can mean that the whole clinic runs very late. You may be asked to wait until the end of the clinic or to re-book.

Home visits:
These are only for patients who are housebound and have no possibility of getting to the surgery. Please request before 11.00 a.m. except in emergency. The receptionist will require some basic details of the need for a home visit in order to prioritise it. You may be telephoned by a clinician prior to being visited by a GP or the practice nurse practitioner. We aim to perform all home visits between 12.00 and 15.00.

Test results:
Please ring between 2-4pm and select option 4 'Test Results'.

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Repeat and acute prescriptions:
We are not allowed to take requests for prescriptions over the phone.
Requests can be made using the re-order form and left in the repeat prescribing box at the surgery, via local pharmacies, by post, or via the NHS Wales App.
Repeat prescription requests take 72hrs from a pharmacy. Requests for acute medications may take longer.
You can ring the prescribing clerks if you have any queries by dialling the surgery number and selecting option 2 'prescription queries'.

Prescribing drugs of addiction:
All the local practices are working together to reduce prescribing these medications as required by the Medicines Management Team of the Local Health Board and the Medicines and Healthcare products Regulatory Authority. The medications include diazepam, sleeping pills, opiate painkillers and gabapentinoids. The doctors and pharmacists will discuss with you how we plan to reduce this area of prescribing. We may need to amend your current medications when you register if they do not comply with our prescribing guidelines.

Expected behaviour:
The Practice supports the government's 'Zero Tolerance' policy for NHS Staff. We aim to give optimal care, kindness and consideration to our patients, and our staff have a right to care for others without fear of being attacked or abused. We understand that contacting your GP can at times be stressful and concerning for patients, and will take this into consideration when trying to deal with a misunderstanding or complaint.
However aggressive, abusive or violent behaviour, or any abuse of our services, will not be tolerated under any circumstances. This behaviour may result in you being removed from the Practice list and the Police being contacted. Examples of unacceptable behaviour include;
• Any physical violence
• Verbal abuse in any form including verbal insults, bad language or swearing
• Racial abuse or sexual harassment
• Persistent or unrealistic demands that cause stress to staff will not be accepted. Requests will be met wherever possible and explanations given when they cannot
• Causing damage or stealing
• Obtaining drugs and/or medical services fraudulently

Complaints Procedure:
Should you be dissatisfied with the service we offer; please contact our practice manager Mrs R Copeland to discuss matters. Information about "Putting things right", our complaints procedure, is available on our website, or from reception.

I have read this contract and agree with the above

Patient signature		Date
Practice signature	*Dr Grahl*, Senior Partner	

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Consent for someone to collect for you
Consent for someone to speak for you

I consent to the following person(s) collecting the below (please tick as appropriate) on my behalf:

☐	Prescriptions
☐	MED3 forms (sick notes)
☐	Documentation being provided to me by the practice

I consent to the practice speaking with the person(s) named below about:

☐	All my health needs
☐	My medication
☐	My test results
☐	The following specific information (please add clear instructions):

Name	Relationship	Contact Details

Patient signature _____ Date _____

If you wish to change these instructions, please contact the Practice.

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New Patient Questionnaire

This form may assist us to provide good care while we wait for your previous medical records. We may contact you to offer support or advice based on your submission. **Thank you for completing this form.**

1) Contacting you	**YES**	**NO**
Preferred Language: English / Welsh / Other (Please specify)		
Email address:		
Mobile (if aged 16 and over):		
Do you have any communication/information needs relating to sensory loss and, if so, what are they and how would you like us to communicate with you?	☐	☐
We have an electronic method of contact available for patients to contact the surgery for non urgent requests – do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose?	☐	☐
Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare?	☐	☐

2) About you	**YES**	**NO**
Do you need/have anyone who looks after you or your daily needs as Carer?	☐	☐
If *Yes*, would you like them to deal with your health affairs here?	☐	☐
Do you care for anyone else?	☐	☐
Are you a family member of someone currently serving in the British Armed Forces?	☐	☐
Are you a student at Aberystwyth University? End date:	☐	☐
Marital status:		
Ethnicity:		

Asian, Asian Welsh or Asian British	**Black, Black Welsh, Black British, Caribbean or African**	**Mixed or multiple ethnic groups**	**White Welsh, English, Scottish, Northern Irish or British**	**Other ethnic group**
Indian	Caribbean	White and Black Caribbean	Irish	Arab
Pakistani	African	White and Black African	Gypsy or Irish Traveller	Any other ethnic group
Bangladeshi	Any other Black, Black British or Caribbean background	White and Asian	Any other White background	
Chinese		Any other Mixed or multiple ethnic background		
Any other Asian background				

Details of Next of Kin

Name:

Contact Number/s:

FOR UNDER 12s

Parent or Guardian's full name:

Full address and contact number if different to that of the child:

3) Medications	**YES**	**NO**
If you are issued a prescription, we can send it to a local pharmacy for you to collect. Please select your **one** preference for collection; **Borth / Boots Aberystwyth / J.Hoots / Morrisons / Talybont / Well**		
Are you on any repeat medication?	☐	☐
If yes please give details:		

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4) Past Medical History	**YES**	**NO**
Do you / or have you ever had any of the following?		
Cancer	☐	☐
Heart condition / problem	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Chronic bronchitis or emphysema	☐	☐
Epilepsy	☐	☐
Depression or mental health issues	☐	☐
Arthritis	☐	☐
High Blood pressure (Hypertension) on medication	☐	☐
Low thyroid status (hypothyroidism) on medication	☐	☐
Are you currently seeing a hospital consultant? *If yes please give details:*	☐	☐
Do you have any allergies? *If yes please give details:*	☐	☐
Have you received a blood transfusion prior to 1996? *If yes please give details:*	☐	☐
Any other health information:		

5) Family History	**YES**	**NO**
Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65? Please specify which relative		
Heart Disease	☐	☐
Stroke	☐	☐
Cancer, if Yes site	☐	☐

6) Lifestyle	**YES**	**NO**
Do you smoke?	☐	☐
Do you vape?	☐	☐
If you smoke or vape, how many tobacco products per day?		
Are you an ex smoker? *If Yes when did you stop?*	☐	☐
How many units of alcohol do you drink a week? *A standard bottle of wine = 10 units. A 175ml glass =2 units. Single small shot of spirits (25ml) = 1 unit. Pint of 4.5% strength lager/beer/cider = 2.5 units.*		
What is your height?		
What is your weight?		

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Immunisation History

	Date – 1st Dose	Date – 2nd Dose	Date – 3rd Dose	X if given in UK
Tuberculosis (BCG)				☐
Diptheria/tetanus/pertussis/polio/ Hib (5in 1) OR				☐
Diptheria/tetanus/pertussis/polio/ Hib/ Hep B (6 in 1)				☐
Pneumococcal (PCV)				☐
Meningitis B				☐
Measles Mumps Rubella (MMR)				☐
Hib/Men C				☐
Diptheria/Tetanus/pertussis/Polio (pre school booster)				☐
Human papillomavirus (HPV)				☐
Meningococcal ACWY (Men acwy)				☐
Tetanus/ Diptheria /Polio				☐
COVID				☐
Other vaccinations				☐

Any additional information:

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