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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

*Not all doctors are authorised to dispense medicines

☐ I live more than 1.6km 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

Signature confirming my consent to join the NHS Organ Donor Register **Date** _____/_____/_____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register **Date** _____/_____/_____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date _____/_____/_____

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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

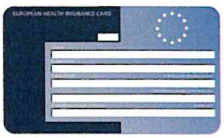
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:
	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	(b) To: DD MM YYYY

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.

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.

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Date: ..... **Title: Mr [ ]Mrs [ ] Miss [ ] Ms [ ] Mx [ ] Other [ ]**

Forename..... **Pronouns: eg: She/Her, They/Their**.....

Surname ..... **Sex: Male [ ] Female [ ] Non-binary [ ] None Specified [ ]**

Address ..... **Sex Assigned at Birth: Male [ ] Female [ ] Intersex [ ]**
I would prefer not to say [ ]
..... (We ask for your assigned sex to help us screen for Sex-specific diseases such as cervical/prostate cancer)

.....

Ethnicity.....
Post Code ..... (As some ethnic communities are susceptible to certain Disease)

Date of Birth.....

Which of the following best describes your religion
Marital Status..... **(NB. These questions are to comply with the discrimination act of 2010)**
None [ ] Buddhist [ ] Christian [ ] (incl. Church of England,
Occupation..... **Catholic, Protestant** and other **Christian denominations)**
Hindu [ ] Muslim [ ] I would prefer not to say [ ]

 **Tel No: Home** .....  **Work** .....  **Mobile**.....

Are you happy for us to leave messages on your telephone? Yes [ ] No [ ]

I consent to the practice contacting me by text/sms messaging on the mobile number above Yes [ ] No [ ]

I consent to the practice contacting me by e-mail on the following e-mail address :_____
and for it to used for any clinic or hospital appointments that I am referred to Yes [ ] No [ ]

Previous Doctor .....

Are you disabled Yes [ ] No [ ]

First Language Spoken.....

Do you require an interpreter [ ]

Do you have any additional communication needs? Please state.....

Do you consent to us sharing your communication needs with other health care professionals? Yes [ ] No [ ]

Are you the main carer for anyone in your household (please state) Yes [ ] No [ ]

Next of Kin: Name.....

Address: .....

..... **Tel:** .....

Is your Next of Kin registered at this surgery Yes [ ] No [ ]

Your relationship to next of kin.....

Please confirm if you are happy for the GP to discuss medical issues with your named next of kin Yes [ ] No [ ]

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Medication

Do you take any medications? Include the name, dose and frequency that you take them – or attach your repeat prescription request sheet. Please state which medicine you purchase from the chemist.

The practice supports EPS (Electronic Prescribing Service – which enables prescribers to send prescriptions electronically to a nominated pharmacy of the patient's choice via the NHS spine). Would you like to nominate a pharmacy or have you previously nominated a pharmacy for your prescriptions to be sent to automatically?

Nominated Pharmacy:.....

Do you have any allergies (please state) Yes [ ] No [ ]

PAST MEDICAL HISTORY:
Please list any illness you have

HOSPITAL ADMISSIONS:
Please list and include dates of any operations if possible

Have you got a long term condition Yes [ ] No [ ]
(please state)

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

High blood pressures	**Yes [ ] No [ ]**	**Diabetes**	**Yes [ ] No [ ]**
Heart disease	**Yes [ ] No [ ]**	**Epilepsy**	**Yes [ ] No [ ]**
Asthma	**Yes [ ] No [ ]**	**Migraine**	**Yes [ ] No [ ]**
Mental illness of any type	**Yes [ ] No [ ]**	**Kidney problems**	**Yes [ ] No [ ]**
Hearing problems	**Yes [ ] No [ ]**	**Bowel problems**	**Yes [ ] No [ ]**
Sight problems	**Yes [ ] No [ ]**	**Urinary problems**	**Yes [ ] No [ ]**
Arthritis	**Yes [ ] No [ ]**	**Indigestion**	**Yes [ ] No [ ]**
Blood problems	**Yes [ ] No [ ]**	**Cancer**	**Yes [ ] No [ ]**
Thyroid problems	**Yes [ ] No [ ]**	**Stroke/TIA**	**Yes [ ] No [ ]**

Please provide details you feel are relevant to the above

Please indicate if you have a family history of stroke or heart disease:
Mother or sister (before age 65) Yes [ ] No [ ]
Father or brother (before age 55) Yes [ ] No [ ]
<u>If Yes please give further details.</u>

HEIGHT:.....**metres/feet**

WEIGHT:..... **kg/ stones**

SMOKING:

Have you <u>ever</u> smoked cigarettes or tobacco? Yes [ ] No [ ]

Are you a smoker now? Yes[ ] No [ ] how many?

If you are an ex smoker when did you give up?

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Would you like advice on how to give up? Yes [ ] No [ ]

DRINKING

How often do you have a drink containing alcohol?

Never [ ] Monthly or less [ ] 2 to 4 times a Month [ ] 2 to 3 times a Week [ ] 4 or more times a week [ ]

How many units of alcohol do you drink on a typical day when you are drinking?

1 or 2 drinks [ ] 3 or 4 drinks [ ] 5 or 6 drinks [ ] 7,8 or 9 drinks [ ] 10 or more drinks [ ]

How often have you had Six or more units (if you are female) or Eight or more units (if you are male) on a single occasion in the last year?

Never [ ] Less than Monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily [ ]

EXERCISE

Do you take 30 minutes a day of at least moderate exercise more than 5 times per week?

Do you take less than 30 minutes a day of physical exercise 5 times a week?

What type of exercise?

DIET

Do you have a special diet? (please state)

Intake of fruit and vegetables less than 5 portions daily?

Intake of fruit and vegetables at least 5 portions daily?

IMMUNISATIONS:

Please tick box if yes and provide if possible

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Tetanus	[ ].....	Flu	[ ].....	Typhoid	[ ].....
Polio	[ ].....	Hepatitis A	[ ].....	Yellow Fever	[ ] .....
MMR	[ ]	Hepatitis B	[ ]	Pertussis	[ ] .....
Rubella	[ ]	BCG	[ ]	(whooping cough)	
Diphtheria	[ ]	Meningitis	[ ]		

Please give the name, relationship and date of birth of any family members who live with you and are registered at this practice;

THIS SECTION TO BE FILLED IN FOR/BY UNDER 16's ONLY

Name of Parent/Guardian .....

School .....

Do you provide regular care to anyone in your household, a family member, friend or neighbour? (please state)
Yes [ ] No [ ]

Safeguarding Our Patients

Beaconsfield Medical Practice is committed to safeguard and promote the welfare of children, young people and vulnerable adults who attend our surgery, if a member of staff is concerned regarding a patient's welfare they have a duty of care to act on that concern.

INFORMATION MAY BE SHARED WITH OTHER PROFESSIONALS

Are you/a member of your family currently subject to or have previously been subject to a child protection plan or 'Looked after Child' care plan? Yes [ ] No [ ]

If yes, who does this relate to?

NHS HEALTH CHECK

If you are aged between 40-74 and not already under review for a chronic disease? Then you are eligible for a free NHS Health Check. Would you like to book a health check? YES [ ] NO [ ]

If you are not entitled to the NHS Health Check above you can have a New Patient Health Check. This 20 minute appointment includes blood pressure, BMI, lifestyle counselling, routine urine testing and cholesterol check if felt necessary. We also offer Chlamydia screening for under 25s. Please contact reception to make an appointment.

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

The practice has a patient participation group who meet every three to four months. Would you be interested in becoming a member?

YES [ ] NO [ ]

Armed Forces

Are you currently serving in the UK Armed Forces Yes [ ] No [ ]

Have you ever served in the UK Armed Forces Yes [ ] No [ ]

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

Your Summary Care Record (SCR) and your Summary Care Record with Additional Information (SCRAI)

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 **only** contains information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

A **Summary Care Record with Additional Information (SCRAI)** contains significantly more useful information. It can include information about medication, allergies, adverse reactions, your illnesses and health problems, operations, vaccinations, 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 about you.

Having a **SCR** or **SCRAI** helps by providing the NHS healthcare staff that are treating you with vital information from your health record. This will help the staff (especially if they do not know you) make better and safer decisions about how best to treat you.

You have the choice of what information you would lie to share and with whom. Please note only authorised NHS healthcare staff can only view your **SCR** or **SCRAI** with your permission and using an auditable means of access. The information shared will solely be used for the benefit of your care and remains confidential.

You can select the option of your choice on the following page.

Updated: May 2020

Beaconsfield Surgery New Patient Health Questionnaire

You have a choice- Having read the above information regarding your choices, please choose one of the options below:

Yes – I would like a Summary Care Record

□ **SCRAI**- Express consent for medication, allergies, adverse reactions and additional information.

□ **SCR** – Express consent for medication, allergies and adverse reactions only.

Or

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record

Name of patient.....

Date of birth.....

Signature..... Date.....

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

Name:.....

Please circle one: Patient Legal Guardian Lasting Power of Attorney and Welfare

Preston Park Community Primary Care Network

175 Preston Road
Brighton
BN1 6AG
01273 557411

New Patient Registration Checklist
TO BE COMPLETED BY CARE HOME STAFF

This checklist is designed to act as an 'aide memoire' for care home staff to gather all the relevant information required for the PCN Care Home Team to undertake an initial clinical assessment and advance care planning, within specified timescales. **Please complete a checklist for all:**

- **NEW RESIDENTS; and,**
- **RESIDENTS discharged back from ACUTE (or other) SERVICES (as they may require a review).**

Patient Details:

Full name:					
Date of birth:		**NHS number:**			
GP Practice:	**Beaconsfield** ☐	**Preston Park** ☐	**Stanford** ☐	**The Haven** ☐	**Warmdene** ☐

Will the patient be a PERMANENT resident?	Yes ☐	No ☐
If NO, is the patient a TEMPORARY resident?	Yes ☐	No ☐
If the patient is a TEMPORARY resident: Will they be a **temporary resident under the COVID-19 Temporary Placements (Discharge to Assess) in Care Homes LCS?**	Yes ☐	No ☐

Note: patients admitted under Temporary Placements LCS need medication review within three (3) working days of admission to the care home by PCN Care Home Team / MOCH Pharmacist.

NB: ALL discharge summaries to be forwarded to the registered Practice as soon as possible.

Note: residents who have **chosen** to spend time in a care home before returning home (and funded themselves) should still be registered as a temporary patient but are **NOT** covered under Temporary Placement LCS.

1. **Above resident registered with PCN practice on DAY OF ADMISSION?** ☐
2. **PCN Care Home Team informed of above resident?** ☐
   (NB: please also highlight patient at first ward round following admission)
3. **Consent form for SCRAI completed?** ☐
4. **Application for Proxy User Access form completed (if appropriate)?** ☐
   (NB: this is for next of kin / care home to have access to clinical record)
5. **Advance Care Planning (ACP) started with patient and carer/relatives?** ☐
   (NB: ACP checklist to support process should be completed)
6. **Has the patient completed a 'My Personal Advance Care Plan'?** ☐

Preston Park Community Primary Care Network

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Preston Park Community Primary Care Network

Dear Resident

The New Enhanced Health in Care Home Service – What does it mean for you?

As a new resident in your care home we are writing to you to introduce a new service that Preston Park Community Primary Care Network will be providing in your home called '*Enhanced Health in Care Homes'* (or 'EHCH' in short).

Preston Park Community PCN is a group of local GP surgeries with whom you are currently registered, or with whom you will be given the opportunity to register. We are working together to provide better care for our patients by sharing resources, skills and best practice.

A key aim of this service is to ensure that the best possible care is provided to residents in care home settings, with the main focus being to provide a more holistic and proactive approach to you and your family. This means promoting your health and reducing the risk of you getting ill in the first place, but if you do to recognise it early and have a plan how we will all deal with it as quickly as possible. This new approach and additional support to your care home will ensure that you continue to receive the best possible care within your home.

Preston Park Community PCN or one of their surgeries will provide a Care Home Team, consisting of doctors, nurses, pharmacists and other staff who can offer a comprehensive, multidisciplinary service. They will also work with other service providers, such as district nurses.

The Care Home Team will provide regular (at least weekly) clinical input to your care home to manage acute and chronic illnesses, complete medication reviews, undertake health promotion and also discuss future health planning with you and your family. This will include discussions around advance care (and, if appropriate for you, they may discuss an end of life care plan), so that both they and all those who care for you can understand your personal wishes and needs.

Preston Park Community Primary Care Network

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In order for this service to work, NHS England have requested that a Primary Care Network and their GP surgeries aim to provide cover to each care home in their local area. This will enable us, and your care home, to provide you with the best possible care.

If you are not registered with one of surgeries aligned to your care home, we would suggest you request the care home arrange for you to re-register as soon as possible and to allow this to happen. Please discuss this with your care home staff, and any relatives or next of kin who may wish to be involved in the decision.

We look forward to providing this service to you and to working more closely with the dedicated staff at your care home.

Yours sincerely

Dr Craig Milne
Clinical Director
Preston Park Community Primary Care Network

Preston Park Community Primary Care Network

175 Preston Road
Brighton
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01273 557411

Your Summary Care Record (SCR) and your Summary Care Record with Additional Information (SCRAI)

Dear Patient,

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 **only** contains information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

A **Summary Care Record with Additional Information (SCRAI)** contains significantly more useful information.

It can include information about medication, allergies, adverse reactions, your illnesses and health problems, operations, vaccinations, 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 about you.

Having a **SCR** or **SCRAI** helps provide the NHS healthcare staff that are treating you with vital information from your health record. This will help the staff (especially if they do not know you) make better and safer decisions about how best to treat you.

You have the choice of what information you would like to share and with whom. Please note only authorised NHS healthcare staff can only view your **SCR** or **SCRAI** with your permission and using an auditable means of access. The information shared will solely be used for the benefit of your care and remains confidential.

The surgeries of Preston Park Community Primary Care Network (PCN) strongly encourage you to consider opting to have a **Summary Care Record with Additional Information (SCRAI)**, as it contains much more information and is therefore significantly more useful to you and the NHS staff treating you.

You have a choice - having read the above information regarding your choices, please choose **ONE** of the options below:

YES – I would like a Summary Care Record

☐ **SCRAI - Express consent for medication, allergies, adverse reactions and additional information**

☐ **SCR -** Express consent for medication, allergies and adverse reactions only

---

NO – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record **(opt out)**

Name of patient:

Date of birth: Date:

Signature:

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

Name:

Please circle one: Patient Legal Guardian Lasting Power of Attorney for Welfare

Preston Park Community Primary Care Network

Primary Care Network
175 Preston Road
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01273 557411

Application for Proxy User Access

PLEASE COMPLETE IN CAPITAL LETTERS

PATIENT DETAILS:					
Title		**First Name**		**Last Name**	
Address					
Gender					

TO BE COMPLETED BY PATIENT:
I give permission to , to give the below named individual/s proxy access to my online medical records and the services as indicated below. I reserve the right to reverse any decision I make in granting proxy access at any time. I understand the risks/benefits of allowing someone else to have access to my health records and I have read and understood the letter provided by the PCN.

I grant permission to allow proxy access to my records:	
***Signature**	
Name and relationship (if signed on behalf of the patient)	
Date:	

*If the patient does not have capacity to consent this should be signed by the person holding the lasting power of attorney for health and welfare or by the GP.

PROXY USER(S) APPLYING FOR ACCESS:					
Title		**First name**		**Last Name**	
Gender		**Date of Birth:**			
Address					
Email address:					
Relationship to patient:					

TO BE COMPLETED BY PROXY USER(S) APPLYING FOR ACCESS:			
We understand our responsibility for safeguarding sensitive medical information and understand and agree with the following statements (please tick):			
I/we will be responsible for the security of the information that I/we see or download.			☐
I/we will contact the practice as soon as possible if a breach of access is suspected by someone without the patients agreement;			☐
If we see information in the record that is not about the patient or that is inaccurate, I/we will contact the practice as soon as possible;			☐
I/we will treat any information that is not about the patient as being strictly confidential.			☐
Signature:		**Date**	
Signature:		**Date**	

Preston Park Community Primary Care Network

175 Preston Road
Brighton
BN1 6AG
Phone: 01273 557411

Information to support Advance Care Planning
TO BE COMPLETED BY CARE HOME STAFF

Patient Details

Name:			
Date of birth:		**NHS number:**	
GP Practice:			

Capacity

Does the patient APPEAR to have capacity to make decisions about their care?

1) Does the person have impairment of mind or brain, whether as a result of an illness, or factors such as alcohol or drug use?
2) Does the impairment mean the person is unable to make a specific decision when they need to? **People can lack capacity to make some decisions, but have capacity to make others.** Mental capacity can also fluctuate with time – someone may lack capacity at one point in time, but may be able to make the same decision at a later point in time. The MCA says a person is unable to make a decision if they can't: understand the information relevant to the decision; retain that information; use or weigh-up that information as part of the process of making the decision; and, be able to communicate the decision.

Yes ☐ No ☐ Not known ☐

If YES, is the patient fully involved in making the plan below?

Yes ☐ No ☐

If NO, does the patient have access to an advocate (i.e. family, friends, other advocate)?

Yes ☐ No ☐ Not known ☐

If NO, *the Mental Capacity Act 2005 requires consultation with an independent mental capacity advocate (IMCA) regarding all decisions made by an NHS body or Local Authority about 'serious medical treatment', where people lack capacity and have nobody to speak on their behalf.* **POhWER** provides access to IMCAs in Sussex / can provide a report for individuals without capacity 2-3 days of referral. Helpline: **0300 456 2370.**

Is there a Deprivation of Liberty Safeguard (DoLS) in place?

Yes ☐ No ☐ Requested ☐

For ALL patients:

Is there a valid Advance Decision to Refuse Treatment (ADRT) (previously known as a *Living Will* or *Advance Directive*) OR an Advance Care Plan already in place?

Yes ☐ No ☐ Not known ☐

If YES, does the patient (or care home) have access to the document(s)?

Yes ☐ No ☐

Does the patient have an existing Personal Welfare Lasting Power of Attorney (LPA)?

Yes ☐ No ☐ Not known ☐

If YES, please enter their name and contact details:

Full name (incl. title):	
Contact number: Mobile / Landline (if available)	
Email address:	

Cardiopulmonary decision / status:

For attempted CPR ☐ **NOT** for attempted CPR ☐ Not aware of CPR decision ☐

Personal preferences:

Preferred place of care:

Care Home ☐ Hospital ☐ Other ☐ If other: give details:

Preferred place of death:

Care Home ☐ Hospital ☐ Other ☐ If other: give details:

Is there a completed 'My advance care plan'?

Yes ☐ No ☐ Not known ☐

Decision making:

Please provide name and contact details of relatives / friends:

Full name (incl. title):	
Contact number: Mobile / Landline (if available)	
Email address:	

Does the patient give consent for Summary Care Record with Additional Information?

Yes ☐ No ☐

Is there a completed form for Proxy Access to patient's GP clinical record?

Yes ☐ No ☐

Form completed by:

Staff / Clinician full name: **Date:**

Signature of staff / clinician completing form:

Preston Park Community Primary Care Network

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175 Preston Road
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Phone: 01273 557411

Guidance notes for completing 'My Personal Advance Care Plan'

What is a Personal Advance Care Plan?

A Personal Advance Care Plan is a page of information about you, developed by you, together with your family or friends (or somebody else) if you need help.

It outlines the decisions you have made about your treatment and the support you need if you become seriously unwell or develop severe COVID-19 symptoms and your carers need to contact emergency services or you may need to be admitted to hospital.

This plan is a way to capture and share, particularly in an urgent situation, the decisions you have made in advance around the care and treatment you would like. In particular with COVID-19 you are likely to be separated from people who usually support you or speak on your behalf, or COVID-19 may make you too unwell to communicate.

If you choose not to go to into hospital and prefer to be looked after in your current home, you will still receive the best possible medical and personal care. For example, pain relief or other appropriate medication and supportive care to ensure you are cared for comfortably. Should you require end of life care this will be done in conjunction with a team of health and social care professionals including your GP, the Palliative Care Team and community (formerly known as 'district') nurses.

What information is required for a Personal Advance Care Plan?

You only need to **note down brief information about the key things** you want people to know under the following headings:

My full name, date of birth, NHS number, what I like to be known as	Basic information about your name, NHS number and how you like to be referred to.
Summary of my health conditions	Briefly list any underlying health conditions
Who am I?	Let us know a few things about you as a person (e.g. things you do when you are well, like drawing and painting or cycling; whether you are a mother of 3 and a grandmother of 5; or, whether you are normally very active etc.)
Three (3) important things I want you to know / What matters to me	This is one of the most important sections as it is a place for you to indicate the preferences you have for treatment if you become seriously unwell or develop COVID-19. • **If you do not want to be admitted to hospital, please record this at number 1.**

	• Include here if your priority is comfort (i.e. managing symptoms) rather than prioritising sustaining your life, which may involve more invasive treatment. • Other things to include in this section might be, for example, that you usually have low blood pressure or body temperature (and tell us what they are if you know them) or that you have a phobia of needles or being sick. Other helpful information would include: • How you react if you are very stressed. • Any treatment you have decided to decline. For example, whether or not you would like to resuscitated with electric shocks and chest compressions if your heart were to stop; or, if you do not wish to have antibiotics for an infection if it would prolong your life but may cause more suffering.
Medication I take	A list of your medication, with doses and frequency (including when you take them).
How my medication is administered	How you take your medication (e.g. orally or through a PEG tube etc.).
How I communicate	It may be that you do not usually use words to speak, or English is not your first language and a family member normally interprets for you. If you do need an interpreter, say what language they would need to understand. It might be useful to let us know how you would indicate distress or discomfort if you are unable to speak.
My emergency contacts	List the names and contact numbers of people you would like us to contact in an emergency.
Who has a copy of this plan?	Please tell us who knows about your plan and who we can contact about it if we need to.

My Personal Advance Care Plan

My full name is:	
I like to be known as:	
My date of birth:	
My NHS number is:	
Summary of my health condition(s):	
Who am I? *Things I do when I am well or something about me as a person*	

Three important things I want you to know:	
1.	
2.	
3.	

Medication I take:	
How my medication is administered:	
How I communicate:	
My emergency contacts:	
Full name of 1st contact:	
Relationship to me:	
Contact details:	
Full name of 2nd contact:	
Relationship to me:	
Contact details:	
Who has a copy of this plan?	