



**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, send us your share code (accessible here - <https://www.gov.uk/evisa/view-evisa-get-share-code-prove-immigration-status>).

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 Sarah Wright, Dr Nicholas Cooper, Dr Andrew Bates, Dr Kate Santer, Dr Natalie Harper, Dr Emma Graney

Manylion y claf

Patient's details

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

| | | | | |
|--|--|---|-----------------------------------|--|
| <input type="checkbox"/> Mr Mr | <input type="checkbox"/> Mrs Mrs | <input type="checkbox"/> Miss Miss | <input type="checkbox"/> 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 |
| <input type="checkbox"/> Gwryw Male | <input type="checkbox"/> 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

| | |
|----------------------|---|
| Cod Post Postcode | Cyfeiriad eich meddyg blaenorol Address of previous doctor |
|----------------------|---|

Os ydych o dramor

If you are from abroad

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

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

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

Ydw
Yes

Nac Ydw
No

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

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

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

Have you ever served in HM Armed Forces?

Ydw
Yes

Nac Ydw
No

Os ydych yn dod yn ôl o'r Lluoedd Arfog

If you are returning from the Armed Forces

Cyfeiriad cyn ymrestru
Address before enlisting

| | | |
|-------------------------------------|----------------------------------|---|
| Dyddiad ymrestru Enlistment date | Dyddiad gadael Discharge date | Rhif gwasanaeth neu bersonél, Rhif BFPO Service or Personnel number, BFPO Number |
|-------------------------------------|----------------------------------|---|

Os oes angen i'ch meddyg weinyddu meddyginiaeth a theclynnau meddygol*

If you need your doctor to dispense medicines and appliances*

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 Iechyd Unigol y GIG

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

NHS Individual Health Record Opt Out

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

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



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



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Practice/Patient Contract

At Ystwyth Medical Group, we strive 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, which may be outside of the practice. 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. We offer telephone appointments as well as face-to-face. Many patients find these more convenient than face-to-face consultation, particularly for follow-up. Please note that we cannot promise to phone at a specific time, but AM or PM.

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. We also offer text message reminders of appointments that include the option to cancel.

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. 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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General Practitioners

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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 eConsult or the NHS Wales App.

Repeat prescription requests take 72hrs to arrive at a pharmacy, and it may take longer than this for them to be processed. Requests for acute medications may take longer.

You can ring the repeat prescribing clerks if you have any queries by dialling the surgery number and selecting option 2 'prescription queries'.

Prescribing drugs:

All the local practices are working together to reduce prescribing certain medications as required by the Medicines Management Team of the Local Health Board and the Medicines and Healthcare products Regulatory Authority. The medications include benzodiazepines, sleeping tablets, opiate painkillers, gabapentin and pregabalin. 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.

Shared care with private providers does not exist in Wales. Any patient who is seen privately and is requesting on-going prescriptions will need to be referred to the NHS service. We can only start prescribing when care is accepted by the NHS service.

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 | <i>Dr Grahl, Senior Partner</i> | | |

General Practitioner Partners
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General Practitioners

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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:

| | |
|--------------------------|--|
| <input type="checkbox"/> | Prescriptions |
| <input type="checkbox"/> | MED3 forms (sick notes) |
| <input type="checkbox"/> | Documentation being provided to me by the practice |

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

| | |
|--------------------------|---|
| <input type="checkbox"/> | All my health needs |
| <input type="checkbox"/> | My medication |
| <input type="checkbox"/> | My test results |
| <input type="checkbox"/> | 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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Immunisation History

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

Any additional information:



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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you consent to the practice contacting you by text message for appointment or vaccination reminders, invitations to health checks, to inform you that your prescription or your sick note is ready for collection and anything else relevant to your healthcare? | <input type="checkbox"/> | <input type="checkbox"/> |

| 2) About you | YES | NO |
|---|--------------------------|--------------------------|
| Do you need/have anyone who looks after you or your daily needs as Carer? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, would you like them to deal with your health affairs here? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you care for anyone else? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a family member of someone currently serving in the British Armed Forces? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you or have you ever worked in the emergency services? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify: | | |
| Are you a student at Aberystwyth University? End date: | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 Pakistani Bangladeshi Chinese Any other Asian background | Caribbean African Any other Black, Black British or Caribbean background | White and Black Caribbean White and Black African White and Asian Any other Mixed or multiple ethnic background | Irish Gypsy or Irish Traveller Any other White background | Arab Any other ethnic group |

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

| 4) Family History | YES | NO |
|--|--------------------------|--------------------------|
| Is there any of the following in your family (<i>father, mother, brother, sister</i>) before the age of 65? Please specify which relative | | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, if Yes site | <input type="checkbox"/> | <input type="checkbox"/> |

| 5) Lifestyle | YES | NO |
|---|--------------------------|--------------------------|
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you vape? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If you smoke or vape, how many tobacco products per day?</i> | | |
| Are you an ex smoker? <i>If Yes when did you stop?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| How many units of alcohol do you drink a week? | | |
| <i>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.</i> | | |
| What is your height (cm)? | | |
| What is your weight (kg)? | | |



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| 6) Medications | YES | NO |
|---|--------------------------|--------------------------|
| Are you on any repeat medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes please give details:</i> | | |
| Have you ever had an Electronic Prescription Service (EPS) nomination at a pharmacy or Dispensing Appliance Contractor (DAC) in England? | <input type="checkbox"/> | <input type="checkbox"/> |
| If you have had a previous EPS nomination that is no longer active (for example you have moved to Wales from England and currently don't use EPS), this is called a 'legacy nomination'. Do you consent to this legacy nomination being removed from your patient record? | <input type="checkbox"/> | <input type="checkbox"/> |
| When EPS is introduced at this GP surgery, and some connected pharmacies and Dispensing Appliance Contractors (DACs), you will have the option of adding a nomination to use EPS. If you would like your prescriptions to go electronically, please provide details of the pharmacy and/or DAC you would like to use: | | |
| <i>Pharmacy:</i> | | |
| <i>Dispensing Appliance Contractor (DAC):</i> | | |

Email your completed form to

registrations.w92025@wales.nhs.uk

Thank you

General Practitioner Partners
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