

### CONTACT DETAILS

NAME:		
DATE OF BIRTH:		
TELEPHONE NUMBER:		
DO YOU CONSENT TO BE CONTACTED VIA SMS AND EMAIL FOR HEALTH MATTERS? (EX. TEST RESULTS)		
YES		NO

WELCOME TO THE  
GRANGE MEDICAL PRACTICE

DR S SINHA   DR J FRYER   DR J Roberts   DR M MUSTAFA   DR I LANE

**BISHOP STREET GRANGETOWN  
CARDIFF  
CF11 6PG**

Tel: 029 2022 6057  
Fax: 029 2064 0524

**SURGERY OPENING HOURS**

MONDAY to FRIDAY: BETWEEN THE HOURS OF 8.30am-18.00pm

**TELEPHONES ARE OPEN**

MONDAY to FRIDAY: BETWEEN THE HOURS OF 8.00am-13.00pm & 14.00pm -18.30pm  
We are closed on Saturdays, Sundays and on Bank Holidays

**HOW TO MAKE AN APPOINTMENT   TELEPHONE 20 226057**

You can make appointments by attending the surgery or by phone.

We run all surgeries by an appointment only system.

Routine appointments can be made one or two a weeks in advance

Appointments are released each morning at 8.am for one or two weeks ahead

Urgent appointments for medical conditions that need to be seen that day and that cannot wait until the next routine appointment **must be made before 10.30** we do not do sick notes or repeat medication in emergency appointments

**TEST RESULTS**

For test results please call the surgery **after 3.00 pm**. Please be aware the results may take several days to be returned to the surgery.

**REPEAT PRESCRIPTIONS**

All repeat prescriptions are computerised and you will be given a white request slip listing medications you can order without seeing a doctor. Requests can be made by ticking the items that you require and handing the slip in at reception, posting it with a stamped addressed envelope, or order online at My Health On-Line.

Patients new to the practice please provide your repeat order slip from your previous practice

Please note we do not take prescriptions over the telephone or accept hospital discharge prescriptions these must be collected at the hospital pharmacy

The surgery operates a **prescription collection service** with all the local chemists. Please advise the receptionist of your preferred chemist, and your prescription will be sent directly to that chemist. You can then pick up your medication directly from the pharmacy without having to collect the prescription from the surgery.

**Please allow 48 hours notice for all repeat prescriptions.**

Visit our website for further information [www.grangemedicalpractice.wales.nhs.uk](http://www.grangemedicalpractice.wales.nhs.uk)



# 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 ☐ Mrs ☐ Miss ☐ 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

### 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 bersonel, 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 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](http://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](http://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

# GRANGE MEDICAL PRACTICE

## PATIENT QUESTIONNAIRE

Welcome to the Grange Medical Practice. Please complete this questionnaire as fully as possible.		
All the information you provide is strictly confidential and will become a part of your medical record		
Title (MR MRS MISS MS )	Marital Status: ( MARRIED DIVORCED SINGLE )	
Surname:		
First Name		
Date of Birth	Male/ Female	
Address:		
Postcode:	Occupation:	
Tel: Home and Emergency contact		
Tel: Mobile		
Tel: Work		
e-mail address		
First Language		
Fluent in English YES NO		
Interpreter required? YES NO		
Do you have someone who looks after your daily needs as a carer? YES NO		
Name and contact details of carer		
Do you look after the daily needs of someone as a carer? YES NO		
Name and contact details of the person you care for		

### Ethnic origin

African		White British	
Bangladeshi		Other mixed background	
British or Mixed British		Other white background	
Caribbean		Pakistani or British Pakistani	
Chinese		Mixed white and Asian	
Irish		Mixed white and black African	
Indian or British Indian		Mixed white and Caribbean	
Other Asian Background		Other	
European : State Country		I do not want to give my ethnic origin	

### Language

Do you speak fluent English?	
What is your first language?	
Do you require an interpreter?	State Country Required :

Do you have a disability we should be aware of? Yes/No	
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## Your medical history

Have you or any member of your immediate family (Mother, Father, Sister, Brother, Child) ever suffered any of the following

Condition	YOU	Which family member?
Stroke		
Raised Blood Pressure		
Heart Disease		
Diabetes		
Asthma other respiratory problem		
Mental health problem		
Thyroid problem		
Epilepsy		
Cancer		

**Please list any serious illnesses or operations (date if known)**

Serious illnesses	
Operations	

**Please give the following information**

Height	
Weight	
Do you/Have you ever smoked? If yes how many a day?	
If you have given up please give a date	
Would you like advice to give up?	
Do you drink alcohol, if yes how many units a week?	
Do you take regular exercise?	

**Please list any allergies you have**

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**Are you taking regular medication? (please state) Do you have a repeat prescription slip?**

**Please give this to the receptionist so we can re-order**

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When did you last have a smear?		
Have you had a hysterectomy?		
Are you taking the contraceptive pill?		
Are you using any other method of contraception?		

When was your last Tetanus injection?

### **New patient check**

All patients over 50 are invited to attend the practice for a health check this will involve height, weight blood pressure, smoking cessation advice and the opportunity to discuss any health concerns you may have.

Please make an appointment for a new patient check with the practice Health Care Assistant

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### **FOR OFFICE USE ONLY**

Address Verified: YES / NO

Staff Member: \_\_\_\_\_  
Date: \_\_\_\_\_