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 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

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood 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:

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 CHSlist 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

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

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Dr Bevan & Partners
Fairfield Park Health Centre

We aim to provide quality Health Services for all people, regardless of race or language. In order to do this, and to comply with national legislation, we need to know more about the population we are serving and are therefore asking you to answer 2 questions on this form. This will help us to provide the right type of healthcare services for all our patients.

The personal information you give us on this form will not be shared with any other organisation, including other Government departments such as The Home Office or The Inland Revenue.

If you have any concerns about the use of this information, please talk to a member of staff.

Thank you for helping us provide a better service to you

If you do not wish to provide any of the information requested, please tick the appropriate box/s below

I do not wish to define my language ☐
I do not wish to define my ethnic origin ☐

If you require any help completing this form, please ask a member of staff.

Please turn over

Name ……

Date of Birth ……

1. What do you consider to be your ethnic origin?

Please tick any appropriate boxes

White			
British		Irish	
Any Other White Background (please specify below)			
Mixed			
White & Black Caribbean		White & Black African	
White & Asian		Other Mixed Origin*	
Asian or Asian British			
Indian		Pakistani	
Bangladeshi		Other Asian Origin*	
Black or Black British			
Caribbean		African	
Somali		Other Black Origin*	
Chinese or Other Ethnic Group			
Chinese		Other Ethnic Origin*	

2. Which language do you usually speak and read?

Language	**Speak**	**Read**	**Language**	**Speak**	**Read**
English			Polish		
Albanian			Punjabi		
Bengali			Russian		
Cantonese			Somali		
Farsi			Spanish		
French			Turkish		
Gujerati			Urdu		
Hindi			Other*		

***If you have ticked any of the boxes marked 'other', please give further details below.**

……

Thank you for your help

Name:

Date of Birth:

Questions	Scoring System 0	1	2	3	4	Your Score
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	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking

The diagram below shows how many units of alcohol there are in a standard drink.

Pint of Regular Beer/Lager/Cider | Alcopop or Can of Lager | Glass of Wine (175ml) | Single Measure of Spirits | Bottle of Wine

REGISTRATIONS – Next of kin details
STRICTLY IN CONFIDENCE

Patients name:……..
Date of Birth:…….

Please sign that you are happy for your doctor to contact your next of kin in an emergency:

Signature:……

Next Of Kin Details:

Name:……
Address:……
……
Tel. Number:……
Mobile Number:……

Please Tick:

- Current smoker *(if you would like support to stop smoking please ask the Doctor or Nurse for a stop smoking pack)*
- Never smoked
- Ex smoker
- Passive smoker

For residential homes:
House security code:…….
Wardens telephone number:……
Carer:……...

IF THESE DETAILS CHANGE PLEASE INFORM THE SURGERY IMMEDIATELY

NHS
Bath and
North East Somerset

We offer our patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications,**
- **and any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission at the time. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice**. If you are happy for a Summary Care Record to be set up for you then you need take no further action**.

If you want to opt-out now please complete the form below and return it to Reception as soon as possible.

Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.

If you DO want a Summary Care Record please dispose of this form
Please complete the form below if you DO NOT WANT a Summary Care Record and return it to Reception.

✂.....

Hand this form in at your Surgery ONLY if you wish to "Opt-Out"

No I do not want a Summary Care Record ☐ Date_____

YOUR NAME:

DATE OF BIRTH:

Signed_____

For more information visit www.nhscarerecords.nhs.uk or call 0300 123 3020.

Please complete this form regarding consent to the Practice sending appointment reminders and/or important health information* by text to your mobile phone.

Name ……Date……...

Date of Birth ……..

Postcode ……

Mobile phone number ……..

☐ I **do** consent to the Practice sending texts to my mobile phone

☐ I **do not** consent to the Practice sending texts to my mobile phone

*We will only ever send information if it is specifically relevant to you personally, e.g. invitations to flu vaccination clinics or chronic disease annual checks etc.

Please note that patient confidentiality is of the utmost importance to us. Only patients who have given consent and had this recorded in their medical records will be sent text reminders and health information. We will not send any texts to patients who have not given consent form even if we have their mobile telephone number on file. Patients who have given consent can opt out of receiving texts at any time by notifying the Practice.