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

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 ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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 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 CHS list 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

Cliff Villages Medical Practice
Grantham Road
Navenby
Lincoln
LN5 0JJ

New Patient Registration Form - Child

Please complete all pages in full using block capitals

1. Background Details

Your Child Details			
NHS Number			
Child Name		Gender	
Address		Date of Birth	
		Home Telephone	

Parent or Guardian Details			
Your Name		Relationship	
Address		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Family Registered With Us			

** It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results or health campaigns or Patient Participation Group details If you do not consent to being contacted by SMS or Email, please tick here:* ☐ *SMS* ☐ *Email*

Other Details				
Previous GP	Name:	Address:		
Country of Birth				
School				
Ethnicity	☐ White (UK) ☐ White (Irish) ☐ White (Other)	☐ Black Caribbean ☐ Black African ☐ Black Other	☐ Bangladeshi ☐ Indian ☐ Pakistani	☐ Arabic ☐ Chinese ☐ Other
Religion	☐ C of E ☐ Catholic ☐ Other Christian	☐ Buddhist ☐ Hindu ☐ Muslim	☐ Sikh ☐ Jewish ☐ Jehovah's Witness	☐ No religion ☐ Other:
Housing	☐ Own Home ☐ Rented Home	☐ Shared House ☐ Sheltered House	☐ Asylum Seeker ☐ Refugee	
Overseas Visitor	☐ Yes	☐ European Health Insurance Card Held (please bring details with you)		
Armed Forces	☐ Family Member			

Communication Needs	
Language	What is your main spoken language? Do you need and interpreter? ☐ Yes ☐ No
Communication	Do you have any communication difficulties? ☐ Yes ☐ No If **Yes** please identify below ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog

2. Medical History

Medical History

Has your child suffered from any of the following conditions?

☐ Asthma ☐ Depression ☐ Diabetes ☐ Epilepsy

Any other conditions, operations or hospital admission details:

<Problems>
<Summary>

If your child is currently under the care of a Hospital or Consultant outside our area, please tell us here:

Family History

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma……. ☐ Heart Disease……..… ☐ Diabetes……..…… ☐ Depression……..……
☐ COPD……...… ☐ Stroke……..…….. ☐ Kidney Disease..…… ☐ Thyroid……..……..
☐ Epilepsy…… ☐ Blood Pressure…… ☐ Liver Disease..…..…….. ☐ Cancer……..

Other:

<Family History>

Allergies

Please record any allergies or sensitivities below

<Allergies & Sensitivities>

Current Medication

Please check and include as much information about your child's current medication below
If they have a previous repeat medication list please give this to us & they may need a medication review appointment

3. Further Details

Electronic Prescribing

Your child's prescriptions will go electronically, please provide details of the pharmacy you would like to use:	Pharmacy:

Parent or Guardian Signature

Signature	I confirm that the information I have provided is true to the best of my knowledge
Name	
Date	

Checklist
Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed & Signed Above Form
- ☐ Completed & Signed GMS1 Form
- ☐ Birth Certificate
- ☐ Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card*
- ☐ Proof of Address *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months*

Practice Use Only

Appointment	☐ Required	☐ Not Required		
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Council Tax	☐ Bank Statement	☐ Other

4. Sharing Your Health Record

Your Health Record

Do you consent to your GP Practice sharing your Child's health record with other organisations who care for them?

- ☐ Yes *(recommended option)*
- ☐ No

Do you consent to your GP Practice viewing your Child's health record from other organisations that care for them?

- ☐ Yes *(recommended option)*
- ☐ No

Your Summary Care Record (SCR)

Do you consent to your child having an Enhanced Summary Care Record with Additional Information?

- ☐ Yes *(recommended option)*
- ☐ No

Parent or Guardian Signature

Signature	
Name	
Date	

Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

<Organisation Details> will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records

For further information about how the NHS uses your data for research & planning and to opt-out, please see:

www.nhs.uk/your-nhs-data-matters

I wish to access my child's medical record & understand & agree with each statement: *Please tick all that apply*

☐ I have read and understood the ‘Important Information’ section below

☐ I will be responsible for the security of the information that I see or download

☐ If I choose to share my information with anyone else, this is at my own risk

☐ I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement

☐ If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

Please bring photographic proof of your identification in order for the process to be completed

Parent or Guardian Signature	
Signature	
Name	
Date	

For Practice Use Only:

Identity verified through (tick all that apply)	☐ Birth certificate ☐ Self vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐ Professional vouching		
Name of Verifier		Date	
Name of person who authorised and added to SystmOne		Date	
Photocopied this page	☐ Yes – Name:		
Passed for scanning	☐ Yes – Name:		