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

052019_006 Product Code: **GMS1**

NHS Family doctor services registration

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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:	
 *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.*	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

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.

Garden City Surgery

57-59 Station Road
Letchworth Garden City
SG6 3BJ

REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK & IN CAPITALS

Surname: ..... First Names: .....

Home Tel: *(Landline only)*..... Work Tel: .....

Mobile Tel: ..... Email: .....

Preferred contact method: Letter/Email/SMS (*circle as required*)

Do you have any information or communication needs? Yes/No

How can we meet your needs ?.....

Consent to use mobile number for text alerts: ☐ *(please tick if you consent)* (XaQid)

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation: .....

What is your Nominated Pharmacy? (*Name & Address*) .....

.....

First Language:

Akan		Gujarati		Punjabi	
Albanian		Hakka		Russian	
Amharic		Hausa		Serbian/Croatian	
Arabic		Hebrew		Sinhala	
Bengali & Sylheti		Hindi		Somali	
Brawa & Somali		Igbo (Ibo)		Spanish	
British Signing Language		Italian		Swahili	
Cantonese		Japanese		Swedish	
Cantonese & Vietnamese		Korean		Sylheti	
Creole		Kurdish		Tagalog (Filipino)	
Dutch		Lingala		Tamil	
English		Luganda		Thai	
Ethiopian		Makaton		Tigrinya	
Farsi (Persian)		Malayalam		Turkish	
Finnish		Mandarin		Urdu	
Flemish		Norwegian		Vietnamese	
French		Pashto		Welsh	
Gaelic		Patois		Yoruba	
German		Polish		Other (*please state*)	
Greek		Portuguese			

Ethnic Origin: (please tick)

White British		Irish	
British/Mixed British		White & Black Caribbean	
Other White		Caribbean	
White & Black African		Other Black	
African		Indian/British	
White & Asian		Bangladeshi/British	
Pakistani/British		Other Mixed	
Other Asian		Other	
Chinese		Would prefer not to say	

Are you a carer? Do you look after someone who relies on you for support? Yes / No

Who do you care for? .....

Do you have a carer? Yes / No Carer's name: .....

Carer's Address: .....

.....

Contact No: .....

Your Next of Kin .....

Their relationship to you .....

Their Address: .....

.....

Contact No: .....

Medical History:

Do you have any current medical problems? Yes / No

Details: .....

.....

.....

Are you taking any medication? Yes / No

If yes, please provide a copy of your repeat list.

Do you have any allergies? Yes / No

Details:

.....

.....

Date of last Cervical Smear: .....

Are you currently pregnant? ..... If yes, date baby due .....

Height: ..... Weight: .....

Family History:

DISEASE/ILLNESS	RELATION	DETAILS
Heart Attack		
Stroke		
Diabetes		
Mental Illness		
High Blood Pressure		
Asthma/Eczema		
Cancer		
Epilepsy/Fits		

Smoking:

Have you ever smoked? Yes / No

Do you still smoke? Yes / No

How many do you smoke a day? .....

When did you give up: .....

Would you like help to stop? Yes / No

OFFICE USE ONLY: Cessation advice given (tick one box)

leaflet given to patient ☐

leaflet sent to patient ☐

Alcohol: Please tick the answer which best applies.

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

1 How often do you have a drink containing Alcohol?

NEVER	MONTHLY OR LESS	2-4 TIMES A MONTH	2-3 TIMES A WEEK	4 OR MORE TIMES A WEEK
☐	☐	☐	☐	☐

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

1 - 2	3 - 4	5 - 6	7 - 9	10 OR MORE
☐	☐	☐	☐	☐

3 **Men:** How often do you have 8 or more drinks on one occasion?
Women: How often do you have 6 or more drinks on one occasion?

NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
☐	☐	☐	☐	☐

OFFICE USE ONLY: TOTAL POINT SCORE : _____/12

Exercise:

Do you take regular exercise? Yes / No

If yes, what sort of exercise? .....

How many times per week? .....

Signed: ..... **Thank you for completing this questionnaire**

OFFICE USE:

	DATA ENTERED		
Nominated Pharmacy	YES / NO	Removed as Out of Area	
Preferred method communication			
Consent to text - XaQid			
NOK information			
Ethnicity			
First language			
Information or communication needs			
Is a Carer			
Has a Carer			
Alcohol			
Smoking status template			
Leaflet given to patient			
Leaflet sent to patient			
Allocated GP			
Named GP			
Consent to organ donor			
Blood donor			
SCR informed dissent			
Registration Completed by & date			
Registration Checked by & date			