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*

**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_____/_____/_____

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:

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

042017_003 Product Code: GMS1

NHS Family doctor services registration

GMS1

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

SUPPLEMENTARY QUESTIONS

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

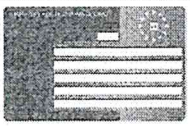
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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.

Westside
Medical Centre

Westside Medical Centre Data sharing "Opt Out" form

I confirm that I know enough about the various data extractions in place or proposed. Please block data extraction from the patient whose details appear below. I specify the precise areas I wish to block below:

Title: Forename: Surname:

Date of Birth: / /

Address: Phone No:

Patient's Signature (or on behalf of) Date: / /

If completing this on behalf of a child, please also complete below:

Your name (BLOCK CAPITALS)

Your signature: relationship to the patient:

Please tick any or all of the 4 areas detailed below that you wish to prohibit data extraction to: If you do not complete this section you will NOT be opted out from data extraction

Area involved Tick those from which you wish to prohibit use of your data Practice use only

Area involved	Tick those from which you wish to prohibit use of your data	Practice use only
1. Summary Care Record (SCR)		9Ndo
2. National "Care.Data" scheme		9Nu0
3. Use of your data from other sources: (A&E, Hospitals etc)		9Nu4
4. Any local (e.g. CCG) Care Record		93C1

PLEASE RETURN THIS FORM TO PRACTICE RECEPTION

Or Email it to the following practice address: westsidemedicalcentre@nhs.net

Westside
Medical Centre

Dr M W Lindsey B Med Sci BM BS MRCGP
Dr C Davies MBBS
Dr E McEvoy MBChB MRCGP MRCS (ENG)

Hilton House, Corporation St, Rugby, CV21 2DN
Tel: 01788 544 744 **Fax:** 01788 563 141

Please FULLY complete this questionnaire to ensure we have as much information about your health to update our records, incomplete application forms will not be accepted. If you are taking any regular medication please attach a copy of your repeat medication list to this application form (this can be obtained from your current surgery), if this is not possible, please bring your medication boxes with you when you hand in this completed application form.

Personal Details *(PLEASE PRINT CLEARLY)*

Forename(s):

Surname:

Date of Birth: / /

Telephone Number(s):

Home: Mobile:

Next of Kin

Title & Full Name:

Relation to Person:

Emergency Contact Number:

In case of emergency, do you give permission for your medical records to be discussed with this person? YES/NO

Text Messaging Service

This Surgery offers a text reminder service to remind you of appointments you have booked. Do you wish to join this service? YES/NO
(If you say yes, we will send reminders to the number you have given above).

(PLEASE NOTE IT IS YOUR RESPONSIBILITY TO NOTIFY THE SURGERY OF ANY CHANGES TO YOUR CONTACT NUMBERS)

Carers

Are you cared for by someone either on a Full or Part time basis? YES/NO
If yes, please specify name and contact number:

Health Information

Do you smoke? YES/NO

If yes, how many per day 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+ ☐

If no, have you ever smoked? If yes, when did you quit and how many did you smoke per day?
Do you drink alcohol occasionally? YES/NO Do you drink alcohol regularly? YES/NO

How many units per week? (UNITS – 1 Pint – 2, 1 small glass of wine – 1, 1 measure of spirits – 1)

Medical History

Do **YOU** suffer with any of the following medical conditions?

ASTHMA ☐ ANGINA ☐ STROKE ☐ HEART ATTACK ☐ GLAUCOMA ☐ DIABETES ☐

Do **YOU** suffer with any other medical conditions? YES/NO
DETAILS:

Do **YOU** have any allergies? YES/NO
DETAILS:

Family History

Is there any family history of the above medical conditions?
(i.e. Parents / Siblings / Grandparents / Aunts / Uncles)? YES/NO
DETAILS:

Ethnic Origin

Westside Medical Centre Equal Opportunity Policy

Westside Medical does not discriminate.

We have a policy to ensure no patient receives less favourable treatment on the grounds of sex, disability, marital status, colour, race or ethnic origin, age, religion, religious belief, sexual orientation, gender reassignment or is disadvantaged by conditions or requirements which cannot be shown by us to be justifiable.

We are committed to an on going programme of action to make this policy fully effective. To ensure this policy if fairly and fully implemented and monitored and for no other reason, would you please complete the information below.

Main Spoken Language:

2nd Spoken Language:

I would describe my ethnic origin as:

WHITE
- British or mixed British
- English
- Irish
- Scottish
- Welsh
- European(which) _____
- Any other White background

ASIAN
- Bangladeshi
- Indian
- Pakistani
- Any other Asian background

CHINESE
- Any Chinese background

MIXED ETHINC BACKGROUND
- Asian/White
- Black African/White
- Black Caribbean/White
- Any other mixed background

BLACK
- African
- Caribbean
- Any other Black Background

ANY OTHER ETHNIC GROUPS

ETHNIC GROUP NOT STATED

Patient Consent

- When it is your turn to see the Doctor/Nurse your name will be displayed on the information board above the information the reception desk.
- There will be times when a Doctor/Nurse needs to examine you physically – if you require a chaperone, please ask.

I have read and understood everything in this questionnaire and agree to be examined.

Name (or on behalf of):

Signed:

Dated:

Health Visitor and School Nursing Liaison

If you have any children aged between 0 and 16 years, please complete this form. This information will be shared with the health visitor (for pre-school children) or the school nursing team (if school age).
Please list children who are registered/registering.

Parent(s) Details

Name:

Address:

Post Code:

Telephone Number(s):

Children(s) Details

Please list only the children who are registered/registering with this practice

Please note: we will need the immunisation record for all patients under 16 years – please bring with you to Surgery either your child's red book(s) or a printout of immunisations from your current GP Surgery.

Child 1: _____ Date of Birth: / /

If school age, name of school: _____

Child 2: _____ Date of Birth: / /

If school age, name of school: _____

Child 3: _____ Date of Birth: / /

If school age, name of school: _____

Child 4: _____ Date of Birth: / /

If school age, name of school: _____