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_____/_____/_____

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

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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

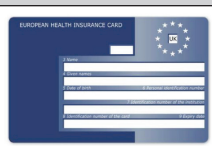
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:
	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

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.

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.

Practice Plus

NHS

Child registration - Health questionnaire

This is an official document of Practice Plus.

Practice Plus

Child registration - Health questionnaire

NHS

Personal details

Name of child being registered

Child's date of birth (DD/MM/YYYY)

Does the child have any siblings and are they registering with the practice? Yes ☐ No ☐

Details of the person completing registration on behalf of the child

Name (Title, First name, Surname)

Address (if different from child's)

Contact number

Email address

Relationship to child Mother ☐ Father ☐ Other (please state)

Please tick to confirm that you have legal responsibility for the child ☐

Emergency contact details (mother, father, legal guardian)

Name

Relationship to child Mother ☐ Father ☐ Other (please state)

Contact number

Permissions

We will need to contact you for example to discuss any results or to invite you to appointments, please let us know how you would like us to contact you.

If you are registering a child under five, please confirm that you wish to register the child with Practice Plus for Child Health Surveillance. Yes ☐ No ☐

Can we contact you by text?	Yes ☐ No ☐
Can we leave a message on your voicemail if we call?	Yes ☐ No ☐
Can we leave a message with a third party if we call (e.g. family or household member)?	Yes ☐ No ☐
Can we email you with information about the practice, health campaigns, patient newsletters etc.?	Yes ☐ No ☐
Do you require any support with communication?	Yes ☐ No ☐
If you need support with translation/interpretation, please state in which language you require this	
Do we have your permission to hold a summary care record for you*?	Yes ☐ No ☐

*The summary care record is an electronic summary of your most important information, such as any long term condition you have and the medicines you are on. It is created from your GP medical records and can be seen and used by authorised staff in other areas of the health care system, for example out-of-hours doctors, or hospital doctors to ensure they are able to give you the best and most appropriate care.

Practice Plus

Child registration - Health questionnaire

NHS

Child's health profile

Height

Weight

Does the child you are registering have any allergies? Yes ☐ No ☐

If yes, please provide details

Does the child you are registering have any ongoing health problems? (Please tick as applicable)

- ☐ COPD
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Repeat infections
- ☐ Anxiety
- ☐ Depression
- ☐ Mental health problems
- ☐ Atrial fibrillation
- ☐ Asthma
- ☐ Epilepsy
- ☐ HF
- ☐ CHD
- ☐ Hypertension
- ☐ Chronic kidney disease
- ☐ Thyroid problem
- ☐ Cancer
- ☐ HIV
- ☐ Stroke

We would like to offer your child a health and lifestyle check (if you don't require an appointment). Please tick if you would like us to arrange an appointment with you. Yes ☐ No ☐

Does the child you're registering have a disability? Yes ☐ No ☐

If yes, please provide details

Is the child you are registering taking any prescribed medications? Yes ☐ No ☐

If yes, please provide details

Would you like to use the Electronic Prescription Service? (This allows you to choose a pharmacy for your child's electronic prescriptions to be sent to) Yes ☐ No ☐

If yes, please provide the name and address of your chosen pharmacy

If your child has an ongoing health problem, a disability or is currently taking a regular medication we need to book an appointment for them so that we can ensure that their care continues and to enable us to continue prescribing their regular medications. We will call you to book an appointment.

Family history – have the child's parents or siblings had any of the following (please tick)

- ☐ Bowel cancer
- ☐ Prostrate cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Breast cancer
- ☐ Other cancer
- ☐ Epilepsy
- ☐ Asthma
- ☐ Ovarian cancer
- ☐ Mental health
- ☐ CVD
- ☐ High blood pressure

If the child is aged 4 or over, please provide the name and address of their school.

Is the child subject to a child protection plan? Yes ☐ No ☐

Is the child in foster care? Foster care ☐ Private foster ☐ Neither ☐

Practice Plus

Child registration - Health questionnaire

NHS

Accessibilty

N.B. These questions are about yourself and not the child you are registering.

To ensure the services we provide are accessible to all, please answer the following questions.

I am happy to answer questions about myself. Yes ☐ No ☐

If yes, please answer the questions below:

What is your ethnic background?

☐ English/Welsh/Scottish/N Irish	☐ Irish	☐ Any other white background	☐ African
☐ Caribbean	☐ White and Black Carribean	☐ White and Black African	☐ Bangladeshi
☐ White and Asian	☐ Any other Black/African/Caribbean background		☐ Arab
☐ Indian	☐ Any other Mixed/Multiple ethnic background		☐ Chinese
☐ Pakistani	☐ Any other ethnicity	☐ Any other Asian background	☐ Rather not say

What is your religion?

☐ Agnostic	☐ Atheist	☐ Buddhist	☐ Christian
☐ Hindu	☐ Church of England	☐ Islam	☐ Jewish
☐ Jehovah's Witness	☐ Pagan	☐ Rather not say	

Further information

If there is any further information you feel it would be useful for us to know please provide it below.

Thank you for completing this form. Please ensure it is handed into your local Practice Plus surgery along with your GMS1 registration form.

HC3881 Jun.18 (4969)