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

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:**	
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	
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	
PRC validity period (a) From:		(b) To:

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.

crossroads
medical practice

Over 18's Health Check Questionnaire

Welcome to Crossroads Medical Practice. To help us provide you with the correct medical care and to make sure that your health needs are addressed; please answer as many of the following questions as you can. Once completed please return forms to the surgery.

Full Name – _____ **Date of Birth-** _____

Telephone Numbers-

Home _____ **Mobile** _____

If you have provided us with a mobile number are you happy for us to text you with appointments etc?

Yes ☐ **No** ☐ **(Please sign)** _____

Are you housebound? **Yes** ☐ **No** ☐

Do you live alone? **Yes** ☐ **No** ☐

Who is your next of kin? Please include contact details _____

What is your employment?

_____

What is your ethnic background? Optional (different groups have different health needs and risks and this information can help us to better plan and tailor our services)

White (British)		Black – African		White/Black African	
White (other)		Black- Caribbean		White/Black Caribbean	
Asian - Indian		Black- Other		White/Asian	
Asian - Pakistani		Chinese		White/Other	
Asian- Bangladeshi		Other Far East			
Asian- other		Any Other (Please Specify)			

Where were you born?

Britain/UK ☐ **Other** (please specify) _____

What is your main language?

English ☐ **Other** (please specify) _____

If your main language is not English, are you fluent in English? **Yes** ☐ **No** ☐

(If no, please advise the receptionist as we will try our hardest to accommodate you)

Would you like us to send you any correspondence in your preferred language?

For patients who are visually impaired, please advise is braille needed?

For patients who have a hearing impairment is sign language needed?

Your lifestyle:

Do you smoke? Yes ☐ **No** ☐ **(if yes how many cigarettes do you smoke a day?)** ☐

If no have you ever smoked? Yes ☐ **No** ☐

How many units of alcohol do you drink a week? (one unit = ½ pint beer, one spirit shot, one glass of wine)

Are you on a medical diet? Yes (please specify) **No** ☐

Please list any allergies or any allergies to Medication -

Do you have or have you ever suffered from:

Asthma	Yes	No	Start Date
Heart Disease	Yes	No	Start Date
Diabetes	Yes	No	Start Date
Stroke	Yes	No	Start Date
High Blood Pressure	Yes	No	Start Date
Cancer	Yes	No	Start Date

Ladies-

Have you had a hysterectomy? Yes ☐ No ☐

If NO, date of last cervical smear

From April 2019 our practice policy for repeat prescriptions has changed. Rather than collecting a paper version your prescription will go to a pharmacy of your choice. Please tick below which chemist you would like to use.

Village ☐ Sainsburys ☐

Crossroads ☐ Morrisons (Lloyds) ☐

Forum ☐ Other (please state) ☐

Asda ☐

Sharing in/out and Summary Care Record

Sharing in/out –

You have two choices which allow you to control how your record is shared. You can change these at any time by letting us know.

Sharing IN – This determines whether or not the practice can view information in your record that has been entered by other services providing care for you.

Sharing OUT – This controls whether your information recorded at this practice can be shared with other healthcare services.

A Summary Care Record is where the hospital have access to any medication you've been given in the past 6 months or any allergies you have. If you have a complicated medical history the hospital will be able to access a more comprehensive summary.

Please circle answer below-

SHARING IN - YES/NO

SHARING OUT - YES/NO

SUMMARY CARE RECORD - YES/NO

TEXT MESSAGING CONSENT

Please fill in your details and read the policy below carefully before signing.

Name of Patient -	Date of Birth -
NHS Number -	
Mobile Tel Number -	
Parent/Guardian name if the patient is under the age of 13. Please state relationship -	

I would like to receive text messages to the above mobile telephone number from Crossroads Medical Practice and understand that the content will only relate to the medical record belonging to myself/my child. It may include confirmation of an appointment or a reminder alert.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing, quoting the above mobile number.

Text messages may be sent to a parent/guardian if the child is 13 years of age or under.

I will advise the practice if I change my mobile number and understand that a new consent form will be required.

I am aware that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed.

I confirm that I understand the details above and that I am the patient listed above. I understand that it is my responsibility to advice Crossroads Medical Practice of any changes to my mobile telephone number.

Signature _____

Date _____

(Form must be signed by the named patient unless the patient is a child under the age of 13 years)