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

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RICHMOND MEDICAL PRACTICE

Child registration (under 15 years)

Please complete this information sheet thoroughly, since it is the start of your child's new medical record with our practice. It forms part of the medical record and as such is completely confidential.

Full Name	
Address **Post Code**	
Telephone Number	
Date of Birth	**Place of Birth:**
NHS No	
Ethnic Origin (Please circle): **Languages spoken**	**White British. White other. Black Caribbean. Black African. Black, other with non-mixed origin. Indian. Pakistani. Bangladeshi. Chinese. Vietnamese. Other Ethnic group with mixed origin. Other Ethnic group.**
Next of kin	**Relationship:**
Previous GP & Medical Practice	**Telephone no**:
Your previous address **Post Code**	

Please record below your child's immunisations - with dates if possible

Primary Immunisations	**Approx age due**	**Approx date given**
Diphtheria/Tetanus/ Whooping cough/HIB injection and Polio	1 8 weeks 2 12 weeks 3 16 weeks	1 2 3
Rotavirus	1 8 weeks 2 12 weeks	1 2
MenB	1 8 weeks 2 16 weeks	1 2
Pneumo (PCV)	1 8 weeks 2 16 weeks	1 2
MMR - Mumps/Measles/Rubella MenB Booster Pneumo (PCV) Booster Hib / MenC Booster	12 - 13 months	- - - -
Pre-school booster (DTP) - Whooping cough/Diphtheria/Tetanus/Polio MMR Booster	3 ½ - 5 years	- -
Diphtheria/tetanus and polio MenACWY MenC	14 – 16 years	- - -
BCG (Tuberculosis)		

Has your child been registered at this practice before? Yes / No

Is your child taking any medication? If so please specify –

……..

……..

……..

Which Chemist would you like prescriptions to be sent to ……

Has your child any allergies (e.g. Penicillin)?

……..

……..

Please advise of any disabilities

……..

……..

Please note below any serious illness, accident or operation your child has had:

Date	Event

Is there anything else you think we should know about your child?

……..

……..

Thank you for completing this form.

Patients Online Service – Book GP Appointments & Order Prescriptions

In order to help improve access to appointments and repeat prescription ordering, you can now book appointments online with any of our regular GP Team. You will be able to cancel and check appointments already booked.

You can also request repeat prescriptions.

This service is available at any time including outside the normal reception hours.

NAME …….

ADDRESS …….

…….....

……

EMAIL ADDRESS ……

DATE OF BIRTH……
(Please note we are unable to issue passwords to parents, if the child is over 13 years. The child would need to sign the request)

DATE OF APPLICATION ……

Please issue a password to enable me to access the System On-Line website. I am aware of the following conditions:

- I accept responsibility for the password and any access to the system using the password.
- I am aware that if I divulge the password to other parties, they will be able to access information about me.
- I agree to inform the Practice immediately if I believe my password has been lost/stolen.
- The Practice can cancel my access (without notification) if there is abuse of the system such as:
  - Booking appointments and not attending.
  - Repeatedly booking and then cancelling appointments.
  - Repeatedly requesting prescriptions that I do not need.

To access this service, please bring in your photographic ID with the completed form.
For children under 13, please bring in the full birth certificate with the completed form.
(Please note a parent has to be registered for online services first)

Signed…….

For Surgery use:

Identification Produced ……

Member of Staff ……

Password Issued on (Date:) ……

SHARING YOUR INFORMATION NATIONALLY

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

We are supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record – Please ask at Reception for an opt out form to complete.**

If you need more time to make your choice please let us know.

For more information talk to our Patient Advice and Liaison Service (PALS) on 0845 602 4384, visit the website **www.lincolnshire.nhs.uk** or **www.nhscarerecords.nhs.uk,** telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020 or ask a member of the practice staff.

Additional copies of the opt out form can be collected from reception, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time be informing us of your wishes.

If you do nothing we will assume that you are happy for us to create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them. If you are the parent or guardian of a child under 16 then you may request to opt them out and we will consider this request. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand then you should make this information available to them.

I have read and understood

Signed …… Date ……

SHARING YOUR INFORMATION LOCALLY

I, **…… Date of Birth ……** have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet "Your electronic patient record & the sharing of information"

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out
I would* / would-not* like the information recorded at **RICHMOND MEDICAL CENTRE** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in
I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **RICHMOND MEDICAL CENTRE**, where I have granted those care teams the right to add to my shared data.

*** Delete as appropriate**

I understand that I can change my decision at any time.

Signed

Patient …….. ….. Date ……

OR

Patient representative …….

Relationship to patient …….

Parental consent form

I ……..(parent's name) have parental

rights for my child ……..(child's name)

I give consent for my child to be brought to the surgery by the following people

…….

…….

…….

…….

…….

…….

…….

…….

…….

I realise that the child might be given vaccinations, examinations, treatment, medication etc at these consultations.

Signed ……..

Date ……..