NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

First names .....

Date of Birth

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 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*

☐ 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

* Not all doctors are authorised to dispense medicines

☐ **Signature of Patient**

☐ **Signature on behalf of patient**

Date .....

Version 01/02

Please see right re: Organ donation

NHS GSM1

I would like to join the NHS Organ Donation Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate.

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

.....

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give blood.

Tick here if you have given blood in the last 3 years ☐

.....

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: .....

To be completed by your 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

.....

☐ 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.

Authorise Signature

Name

Date

Practice Stamp

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