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

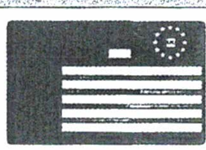
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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



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.

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		
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.

Please note that Clarendon Lodge Medical Practice are involved in 'GP2GP' We would like to draw to your attention, therefore, that if you ever leave and re-register with a new doctor, your medical notes will be sent electronically to your new GP Practice.

Identity verified by (initials) RECEP TO CHECK:-	Date	Photo ID Driving Licence ☐ Passport ☐ ID Card ☐	Proof of Residence Bank Statement ☐ Utility Bill ☐ Council Tax ☐
		RECEP PLEASE TICK ONE OF EACH	

NEW PATIENT HEALTH CHECK

NEW PATIENT APPOINTMENT WITH OUR PRACTICE NURSE/HEALTH CARE ASSISTANT

Date of New Patient Check appointment: ..... Time: .....

Welcome to Clarendon Lodge Medical Practice. We would be grateful if a confidential questionnaire could be completed for every new patient registering with the practice.
Once the completed questionnaire is returned, together with the attached 'family doctor services registration form', we will be able to proceed with your registration.
We offer all patients, registering with the Practice, a "new patient consultation". We strongly recommend that you make an appointment because the information gained at this meeting and through the questionnaire, helps us to provide you with the best care and attention possible.

Thank you for your time.

Surname	**First Name/s**
Title	**Known as**
Date of birth	**Occupation**
Ethnic Group	**First Language**
Next of Kin **Contact telephone number for next of kin**	

Do you have a carer? ☐ yes ☐ no If yes please give name and contact telephone number

.....

Are you a carer? ☐ yes ☐ no If yes, please give name, relationship to you (with their permission) (not as your employment) and contact number. Is this person a patient at this practice? Y?N

.....

PERSONAL MEDICAL HISTORY

1.	Significant Illnesses/Conditions (please tick relevant boxes)				
Insulin treated diabetes	☐	Tablet treated diabetes	☐	Diet controlled diabetes	☐
High blood pressure	☐	Heart disease	☐	Asthma	☐
Cancer	☐	Epilepsy	☐	Thyroid problems	☐
Stroke	☐	Other chest problems	☐	Other	

2.	Operation/s	Date/s

3.	Other Admission/s to hospital	Date/s

FAMILY MEDICAL HISTORY

(please tick relevant boxes)

High Cholesterol of 7.5 or greater ☐			If so, which member of the family?		
Heart Attack ☐	If so, which member of your family? How old were they when they had the heart attack?				
Heart disease ☐	Stroke ☐	Cancer ☐	Diabetes ☐	Hypertension ☐	Asthma ☐
Other ☐ (please specify)					

DRUGS AND MEDICINES

(please tick relevant boxes)

Are you being prescribed medication on a repeat basis	☐ yes ☐ no
Are you allergic to any medications? ☐ yes ☐ no If yes, please state	

DISABILITY INFORMATION

(please tick relevant boxes)

Partially sighted ☐	Blind ☐	Hearing impaired ☐	Deaf ☐	Speech Defect ☐
Dyslexia ☐	Learning disability ☐	Mental Illness ☐	Mobility problem (please explain) ☐	

LIFESTYLE

(please tick relevant boxes)

Do you smoke? yes ☐ no ☐	If yes, number per day ……..
If 'no' are you an ex-smoker?	yes ☐ no ☐

How often do you have a drink that contains alcohol?	Never ☐	Monthly or less ☐	2-4 times per month ☐	2-3 times per week ☐	4+ times per week ☐
How many units of alcohol do you have on a typical day when you are drinking?	1-2 ☐	3-4 ☐	5-6 ☐	7-8 ☐	10+ ☐
How often do you have 6 or more standard drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/almost daily ☐
Scoring System	0	1	2	3	4
A total of 5+ indicates increasing or higher risk drinking. If you score 5+ we recommend that you make an appointment with one of our nursing team.					**Overall score =**

Exercise	Very active ☐	Moderate ☐	Gentle ☐	Inactive ☐

Diet	Good ☐	Moderate ☐	Poor ☐	Vegetarian ☐	Vegan ☐

ABOUT YOU

(please tick relevant boxes)

Height ……..	Weight ……

Non-drug allergies (ie nuts, insect bites, pollen) ……			
Mild ☐	Moderate ☐	Severe ☐	Very Severe ☐

Do you take Aspirin regularly, which you buy over the counter? Yes ☐ No ☐

Have you had any of the following immunizations? Please give the date (year will suffice) and stage ie booster etc.

Tetanus ☐		date ……	stage ……
Combined Diphtheria/Tetanus ☐		date ……	stage ……
Polio		date ……	stage ……
Flu ☐	date ……	Pneumovax ☐	date ……

FOR WOMEN

Form of contraception used:

The Pill ☐	Coil (IUD) ☐	Condom ☐	Diaphragm (Cap) ☐

Ethnicity

Name : ..... DOB .....

White				
British		Irish		
Other				
Mixed				
White/Black Caribbean		White/Black African		
White/Asian		Other mixed background		
Asian				
Indian		Pakistani		
Bangladeshi		Other Asian background		
Black or Black British				
Caribbean		African		
Other				
Chinese				
Other				
Other		Unknown		

Religious Beliefs

Baha'i		Buddhist	
Christian		Hindu	
Jain		Jewish	
Muslim		None	
Pagan		Sikh	

Zoroastrian		Unknown	
Other			

Sexual Identity

Name : ..... DOB .....

Heterosexual/Straight		Gay or Lesbian	
Bisexual		Other	
Unknown			

IF YOU DO NOT WANT A SUMMARY CARE RECORD PLEASE COMPLETE AND SIGN THIS FORM.

IF YOU DO WANT A SUMMARY CARE RECORD, PLEASE DISREGARD THIS FORM.

What is the NHS Summary Care Record?

The new NHS Summary Care Record is being introduced to help deliver better and safer care and give you more choice about who you share your healthcare with.

The Summary Care Record will contain basic information about any allergies you may have, unexpected reactions to medications and any prescriptions you have recently received.
The intention is to help clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access in unnecessary.

Children under the age of 16

Patients under 16 years will not receive this letter, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you decided to proceed, but at any time in the future you, or a child you are responsible for, change your mind and choose not to have a Summary Care Record, all you need do is write to your Surgery informing them of your decision to "Opt-out". If you have already told your Surgery that you wish to "Opt-out" and you wish this to remain in place you need take no further action.

PLEASE ONLY COMPLETE AND SIGN THE BOTTOM SECTION IF YOU DO NOT WANT A SUMMARY CARE RECORD. Otherwise disregard this form.

Patient Name.....

NHS Number (***if known***) ..... Date of Birth .....

Signed by Patient ..... Date .....

Electronic Prescription Service

If you have nominated a Pharmacy previously using this system and then recently joined our Practice – please ensure that your nominated Pharmacy is up to date – either with the Practice or your new Pharmacy of your choice.

For more information on the Electronic Prescription Service visit – www.connectingforhealth.nhs.uk/eps

If you wish to use the Electronic Prescription Service – please ask at your local Pharmacy or at Reception at Clarendon Lodge.

Please complete the Nomination form below to enable us to update your records if you wish to use this service

Nomination Form for Electronic Prescriptions

Name ..... Date of Birth.....

Address .....

Nominated Pharmacy/ Name of pharmacy

.....

Address of Pharmacy :

.....

Post Code of Pharmacy .....

Signed: ..... Date .....

Clarendon Lodge Medical Practice

Application for online access to my medical record

Surname	**Date of birth**
First name	
Address **Postcode**	
Email address	
Telephone number	**Mobile number**

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my Summary of Medical Record	☐
Accessing my Detailed Coded Records – *Please ask at reception for full details how to register*	

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	**Date**

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials) **RECEP TO CHECK:-**	**Date**	**Photo ID** **Driving Licence ☐** **Passport ☐** **ID Card ☐**	**Proof of Residence** **Bank Statement ☐** **Utility Bill ☐** **Council Tax ☐** ***RECEP PLEASE TICK ONE OF EACH***
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐			Notes / explanation

Clarendon Lodge Medical Practice

Online Medical Record Access –Detailed Coded Records

This practice also offers you the opportunity to use the internet to securely view your electronic medical record held by the surgery. There are also links to information leaflets about diseases, tests, investigations, support groups and medications and links to websites such as NHS Choices and patient.co.uk where you can find more information to help you understand about what you read in your record.

The system allows you to view the following areas of your medical record:

- A summary that gives you the most important and recent entries in your health record
- Allergies
- Patient Information Leaflets linked from the diagnoses in the medical record section
- Results showing recent investigations such as blood results, blood pressures and x-rays
- Some vaccinations
- Medications
- Consultations

NB The service is currently only available for patient aged 16 and over. We hope to extend this facility to the under 16s at a later date.

Should you wish to access your Detailed Coded Records - Please ask at Reception for further information and application form.

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Accessible Information Standard

As part of the accessible information standard we wish to make sure that patients and service users, and their carers and parents, can access and understand the information they are given by Clarendon Lodge Medical Practice

If you have any information or communication needs - which relate to a disability, impairment or sensory loss. We can provide for instance letters in large print or Braille, or if you require an interpreter/ translator for consultations with the Doctor or Nurse. **Please ask Reception for an information form.**