# 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 aGP

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 |
|---|---|---|---|---|---|

# 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.

# SLEIGHTS & SANDSEND MEDICAL PRACTICE

# NEW PATIENT HEALTH QUESTIONNAIRE

**Office use only**

Emis no .....

☐ HCA apt

Apt date .....
please book 4 weeks from date of registration

Identity documents seen:
☐Passport
☐Driving licence
☐Bank statement
☐Utility bill
☐Other, please state

.....

☐GMS1
☐ EHIC /S1 card holder
Collect details and send to
EHIC - NHSDigital-EHIC@nhs.net S1 - overseas.healthcare@dwp.gsi.giv.uk

☐Add Clinical code 9Ny

## IMPORTANT INFORMATION

Thank you for applying to join Sleights and Sandsend Medical Practice please complete the enclosed details and return to the Practice. Please note that before we can formally register you with the Practice you will need to attend a new patient health check and we will need to see photographic identification and at least one proof of address document.

*Photographic identification includes a passport, a UK photocard driving licence or nationally recognised photo ID. Proof of address includes utility bills or recent bank statements. If you are unsure please speak with a receptionist*

## PERSONAL DETAILS

Surname: ..... Forename(s): .....

Date of Birth: ..... Mobile No.: .....

Email address: ..... .....

If you are of school age, are you home schooled? ☐ YES ☐ NO

Are you allergic to any substances or foods? ☐ YES ☐ NO

If yes, please give details:
.....

Ethnicity: .....

## NEXT OF KIN

Surname: ..... Forename(s): .....

Date of Birth: ..... Relationship to you .....

Address ..... .....

..... Postcode .....

Contact telephone numbers.....

.....

Emergency contact ☐ YES ☐ NO

Can discuss record ☐ YES ☐ NO

*This relates to discussing your medical record in the event of an emergency if required. It does NOT include routine sharing of information. If you would like to nominate a person to have permission to discuss your medical record please supply a separate letter of consent*

## LIVING IN A RESIDENTIAL INSTITUTION

Under Primary - Care CCG information select appropriate text

Do you live in a care or residential home ☐ YES ☐ NO

Are you a student residing at local school or university ? ☐ YES ☐ NO

## IF YOU HAVE A CARER

☐Add Clinical code 918F

Are you dependent on someone for some or all of the time? ☐ YES ☐ NO

If yes name of person .....

Relationship to you ..... Contact tel: .....

## IF YOU ARE A CARER

☐Add Clinical code 918G

Do you look after someone who is dependent on you for some or all of the time? ☐YES ☐NO

If yes name of person ..... .....

Relationship to you ..... Contact tel: .....

Are they a patient at Sleights & Sandsend Medical Practice? ☐ YES ☐ NO

## DISABILITY

☐Add Clinical code 13VC
Physical disability 13VM
Learning disability HNG0625
☐Add alert

Do you have a disability ☐ YES ☐ NO

Type of disability.....

You do not have to provide this information but it will help us to help you. We have an additional bell on the front door at Churchfield surgery which may be used if you require assistance with entering the building.

## COMMUNICATING WITH YOU

Do you have any information and/or communication support needs e.g. interpreter, information or letters in larger type or use braille. ☐ YES ☐ NO

If "Yes" please let us know what support you need. *For example – hearing difficulties require a hearing loop; visually impaired require large print*

.....

.....

Do you give permission for this information to be shared with other healthcare organisations as and when required? ☐ YES ☐ NO

Complete notification preference in registration box

You will be automatically registered to receive messages by email, mobile phone & SMS text message. This includes appointment reminders, messages to remind you about important information such as flu clinics, closures of the Practice and the friends and family test.

If you do NOT want to be registered please tick here ☐

Process on line registration using ID supplied for registration. Provide on line access information leaflet and registration document.

You will also be registered to use on line patient access. Please note you must have an individual email address to ensure you can use this service. It allows you to book appointments/order repeat medication and access your medical records
If you do NOT want to be registered please tick here ☐

**SLEIGHTS & SANDSEND MEDICAL PRACTICE PATIENT PARTICIPATION GROUP**
Would you like to join our Patient Participation Group? Your participation and feedback help to ensure we offer the best possible service. ☐ YES ☐ NO

☐if yes add code 9NS9

If YES would you like to attend meetings ☐ YES ☐ NO
or be on the virtual group and only be contacted by email ☐ YES ☐ NO

## SUMMARY CARE RECORD

If you are registered with a GP practice in England you will already have a SCR, unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a SCR can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. Your options are outlined below please tick and sign below

☐ add code 9NuB

☐ **Express consent for medication, allergies and adverse reactions only.** *Shares information about medication, allergies for adverse reactions only.*

☐ add code 9Ndm

☐ **Express consent for medication, allergies, adverse reactions and additional information.** *Shares information about medication, allergies for adverse reactions and further medical information that includes: Your illnesses and health problems, operations and vaccinations you have had, how you would like to be treated (eg: where you prefer to receive care), what support you might need and who should be contacted for more information about you.*

☐ add code 9Ndo

☐ **Express dissent for Summary Care Record (opt out).** *Select this option, if you* ***DO NOT*** *want any information shared with other healthcare professionals involved in your care.*

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions. You are free to change your decision at any time by informing your GP practice.
You can find further information at:
http://systems.digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678

☐ Summary care record opt out form completed

Signature: ..... Date: .....

## YOUR DATA MATTERS AND OUR PRIVACY NOTICE

Please read carefully the enclosed leaflet regarding the way the NHS uses your data. It is your responsibility to decide how your data can be used and if you do not want your confidential patient information to be used for research and planning you can opt out. To find out further information or to opt out follow the information provided on the leaflet.

Our Privacy Notice may be viewed on our website and in the practice waiting room

## PARENTS

If you are registering a child under 5 please note the Child health surveillance programme is more correctly termed the Healthy Child programme and aims to help parents develop a strong bond with children; encourage care that keeps children healthy and safe; protect children from serious diseases, through screening and immunisation; reduce childhood obesity by promoting healthy eating and physical activity; encourage mothers to breast-feed; identify problems in children's health and development and safety so that they can get help with their problems as early as possible; make sure children are prepared for school and identify and help children with problems that might affect their chances later in life.

You may also use patient access on behalf of your child(ren) up to the age of 11. At which time we will contact the young person to see if they still wish to allow their parent or guardian access to this service. If not we will deactivate the access. Irrespective of this decision once the young person reaches 13 they can register for themselves and they will be issued with a new personal access and password. We have a duty to patients to protect their confidentiality and ensure information is only available to the appropriate person.

## MEDICATION

☐ list received or

☐GP apt made

Apt date .....

Please provide a list of medication from your previous surgery. If you do not have this information the Receptionist will make you an appointment with a GP so that the medication can be added to your record.

## PATIENT DECLARATION

By signing below you are declaring that the information contained within this patient registration form is accurate to the best of your knowledge.

Signature ..... Date .....

If registering on behalf of someone else

Signature ..... Date .....

Relationship to patient ..... .....
*Parent /legal guardian/lasting power of attorney*

☐add clinical code 67DJ Informed patient of accountable GP ☐add clinical code 9nn60 allocated accountable GP

**Thank you for completing this information. Your named GP at the Practice will be**

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