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

Mobile 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 and appliances*

**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

Version 01/02

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor 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

Signature confirming consent to organ donation **Date**

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

NHSBlood 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:

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 CHSlist 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

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

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New Patient Registration Form Date:

Please complete this confidential questionnaire (**one for each member of the family to be registered with the Practice**).

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Full Name:					Telephone Number:	
Mr / Mrs / Miss / Ms / Other….					Work Number:	
Address and Postcode					Mobile Number:	
					E-mail Address:	
					Next of Kin:	
					Next of Kin Contact Number:	
Date of Birth:		Your named GP will be:			Town & Country of Birth:	
If you are under the age of 18 Please list **all** adults over the age of 18 living in the same household						
Marital Status:		Gender:	Male:	Female:	Previous / Mother's Surname if different:	
NHS Number *(If known)*					School Attended:	
Your Height:	Feet / Inches	Cm	Your Weight:		Stones / lbs	Kg

Your Religion:	C of E	Catholic	Other Christian (*state*)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No Religion	Other Religion (state)	

Your Ethnic Origin: (*select one*)	White (UK)	White (Irish)	White (Other)

Caribbean	African	Asian	Other Mixed Background
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi	Other Asian Background
Other Black Background	Chinese	Other	Ethnic Category not stated

Your main or 1st language Spoken / Understood: (*select one*)	English	Hindi	Gujurati	Urdu	Bengali/ Sytheti	Punjabi

Polish	Ukrainian	French	German	Spanish	Other: (*Please Specify*)

Diet	Eating Habits		Type of Diet	
	Good		Vegetarian	
	Moderate		Vegan	
	Poor			
	Not Examined			
Exercise	Inactive		Vigorous	
	Moderate		Gentle	

Any Significant Illness (Past or Present) and Date of Diagnosis (if Known)	

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker ?	Yes	No
If so, how many cigarettes / cigars / Tobacco do you smoke in a week?			How much alcohol do you drink in a week (units)? (*one unit = 1 small glass of wine, a single measure of spirits, or ½ a pint of beer*)		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	No. times per week		Type(s) of exercise:		

Please list any tablets, medicines or other treatments you are currently taking: (*include: dose + frequency*)	

Are there any serious	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer

diseases that affect your Parents, Brothers or Sisters (*tick all that apply*)	Breast Cancer	High Blood Pressure	Asthma	Stroke
	Thyroid Disorder	Any other important Family Illness?		

Military Veterans	
If you have ever been in the Armed Forces please give details and dates (this includes National Service)	
Details	
Dates	
If you agree to this information being included in your Medical records please sign here	
Signature:	
Date:	

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have. (*i.e. Speech, Hearing, Sight*): Do you have any information or communication needs that you need us to know about? If you would like to receive letters or information in an alternative format please state here.(eg larger print)		
Are you an 'Assistance Dog' User?		
Do you require the help of a Translator / Interpreter?		
Please state any allergies and Sensitivities you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	<u>Person Cared for Contact Details:</u>	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	<u>Carer Contact Details:</u>	
	<u>Signed:</u>	<u>Date:</u>

Summary Care Records

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide:

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Patient Signature:		Signature on Behalf of Patient:	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).
The consultation will also establish relevant past medical and family history, including:

- Medical factors – Illnesses, immunisations, allergies, hereditary factors, screening tests, current health
- Social factors – employment, housing, family circumstances
- Lifestyle factors – diet and exercise, smoking, alcohol and drug abuse.

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack
Or see our website: www.argylestreetmedicalcentre.co.uk

FOR PATIENTS AGED 16 AND OVER

For the following questions please **circle** the answer which applies to you

1 drink = ½ pint of beer / 1 glass of wine / 1 single spirits

1. Men: How often do you have EIGHT or more drinks on one occasion?

   Women: How often do you have SIX or more drinks on one occasion?

   Never **Less then Monthly** **Monthly** **Weekly** **Daily or almost daily**

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking.

   Never **Less then Monthly** **Monthly** **Weekly** **Daily or almost daily**

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never **Less then Monthly** **Monthly** **Weekly** **Daily or almost daily**

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   Never **Less then Monthly** **Monthly** **Weekly** **Daily or almost daily**

Thank you for your time in completing our questionnaire.

ONLINE ACCESS

If you require online access when registering with the practice, please sign the consent section below, please provide signed identification
The staff will issue a unique Reference number for you to register your access.

Name: DoB:

Date:

Email address:

NOMINATE A PHARMACY

Please state the nominated pharmacy you require your prescriptions to be sent to

Pharmacy name:

Address: