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

052019_006 Product Code: **GMS1**

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To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date _____/_____/_____

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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
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.		
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

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.

HEALTH QUESTIONNAIRE

This document must be completed by patients to provide basic health information.

NAME: _____ **Date of Birth:** _____

Name of parent (if under 10yrs) _____

Tel: **Mobile:** **Email:**
Occupation: _____ **Next of Kin Name & Tel:** _____
Relationship to you: _____

Is English your first language? Yes/No **If not, what is your first language?** _____
Is an interpreter required? Yes/No

SMOKING:

- **Do you smoke?** Yes / No **If Yes,** how many do you smoke per day _____
  (If you would like to stop smoking, please make an appointment to see one of the partners.)
- **Smoking advice given?** Yes / No (Appointment/leaflet given)
- **Have you ever smoked?** Yes / No **If yes, how many did you smoke per day?** _____
- **When did you stop smoking? --/--/----**

Estimated Weight: Estimated Height: Estimated Waist Circumference:
Blood pressure checked in last 5 years? Yes / No
Tetanus jabs in last 10 years? Yes / No / don't know Approximate Date:

ALCOHOL:

Place an X in one box that best describes your answer to each question.
(1 unit=half pint of lager, 1small glass wine, or a single pub measure of spirits)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

DIET:

Please circle the most applicable diet to you:
DIABETIC / VEGETARIAN / WEIGHT REDUCING / OWN DIET

EXERCISE:

How many times per week do you exercise for over 30 minutes?

FAMILY HISTORY:

Is there any of the following in your family before age of 65?

Heart Disease	Yes/No	Which family member?
Stroke	Yes/No	Which family member?
Hypertension requiring medication:	Yes/No	Which family member?
Diabetes	Yes/No	Which family member?
Cancer	Yes/No	Which family member?

DO YOU CONSENT TO A SUMMARY CARE RECORD? Yes/No

HIV TEST:
Would you like to be tested for HIV? Yes/No

CARERS:
Do you care for anyone else's daily needs? Yes / No
Do you have a family member who looks after you and your daily needs? Yes / No

If female, have you had a cervical smear? Yes / No
If yes, when was your last smear?
What was the result of the last smear? Negative, / Positive, / Unsatisfactory, repeat.

What is your ethnic group? *Choose ONE section from A to E, and then tick the appropriate box on the right to indicate your ethnic group.*

ETHNIC GROUP	TICK HERE
A: White	
British	
Irish	
Any other White background (please write in line below)	
B: Mixed	
White and Black Caribbean	
White and Black African	
White and Asian	
Any other mixed background (please write in line below)	
C: Asian or Asian British	
Indian	
Pakistani	
Bangladeshi	
Any other Asian background (please write in line below)	
D: Black or Black British	
Caribbean	
African	
Any other Black background (please write in line below)	
E: Chinese or other ethnic group	
Chinese	
Any other (please write in line below)	
Not stated/declined	
Declined: patient chooses not supply this information	

IF THE REGISTRATION IS FOR A CHILD PLEASE BRING THE RED BOOK OR RECORDS OF ANY IMMUNISATIONS SINCE BIRTH TO THE SURGERY.

Have you ever had or have a history of:

Drug/Alcohol/Substance Misuse?	Yes	No
Violence/Domestic Abuse?	Yes	No
Safeguarding children concerns?	Yes	No
Known to Social Services?	Yes	No
Any Mental Health concerns?	Yes	No

Staff Use Only

Named GP allocated: _____
Patient Notified Yes/No

Nominated Chemist (EPS) _____

Checked by: _____

The Fryent Way Surgery

Application for online access to my medical record

First name	Surname
Date of Birth	
Address	
Postcode	
Email address (CAPITAL LETTERS)	
Landline number	Mobile number

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

1. Booking appointment	☐
2. Requesting repeat prescriptions	☐
3. Access to my medical record	☐

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

1. I have read & understood the leaflet *'What you need to know about your online GP records'*	☐
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 staff use only

ID verified by (initials):	**Date:**	**Method**
		Vouching ☐ Vouching with information in record ☐ Photo ID ☐

Free TB Screening (Eligibility form)

This form will help determine if you are eligible for a FREE TB test. For more information on the TB programme please see **www.thetruthabouttb.org/latent-tb**

Please complete ALL questions, unless you have circled No to questions 2 or 3.

1. Please write your country of birth? .....
2. Have you lived in the UK for less than 5 years? Yes / No (Please circle)
3. Have you lived in any of the below countries for 6 months or more? Yes / No (Please circle)
4. Are you between the ages of 16-35? Yes / No (Please circle)

(If you have answered **Yes** to **Questions 2 and 4 or 3 and 4,** please continue, if you have answered **No** to any of the above questions you **do not** have to complete the rest of this form.)

5. Are you from/ did you move to UK from one of the following countries, **listed below**? Yes / No (Please circle).

Country	Country	Country	Country
Afghanistan	DR Congo	Lesotho	Papua New Guinea
Angola	Djibouti	Liberia	Philippines
Bangladesh	Equatorial Guinea	Madagascar	Republic of Moldova
Benin	Eritrea	Malawi	Rwanda
Bhutan	Ethiopia	Mali	Sao Tome and Principe
Botswana	Gabon	Marshall Islands	Senegal
Burkina Faso	Gambia	Mauritania	Seychelles
Burundi	Ghana	Mauritius	Sierra Leone
Cote d'Ivoire	Greenland	Micronesia Moldova	Somalia
Cabo Verde	Guinea (Republic of)	Mongolia	South Africa
Cambodia	Guinea-Bissau	Mozambique	South Sudan
Cameroon	Haiti	Myanmar (Burma)	Swaziland
Central African Republic	India	Namibia	Timor-Leste
Chad	Indonesia	Nepal	Togo
Comoros	Kenya	Niger	Tuvalu
Congo	Kiribati	Nigeria	Uganda
DRP Korea	Laos PDR	Pakistan	Tanzania
			Zambia
			Zimbabwe

5. If you were born in one of the countries above:

Do you have a bad cough? Yes/No ; Do you sweat a lot at night? Yes/No ; Have you lost a lot of weight in the last year? Yes/No

Thank you for completing this form, please hand the forms to reception.

Office use only

If patient has answered **yes** to questions 2 & 4 or 3 & 4 and has circled one of the countries in the table the patient is eligible for TB screening. Please offer the patient a blood test (IGRA) to see if they are at risk of Tuberculosis (TB) .
If the person said Yes to any of the questions in (5) please make an urgent appointment to be screened for active TB
FAO receptionist: If patient is eligible for TB screening, please mark on the top of this form **"patient is eligible for LTBI Screening** "and hand form to registrations person so patient can be scheduled for a blood test ASAP.**FAO: Registration Person,** please use the 'born in read code' for the country circled above.