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 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_______/________/________

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

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:

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

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

New Patient Questionnaire

The Village Surgery
12 Elbow Lane, Formby
L37 4AW
Telephone: 01704 878661

Freshfield Surgery
61 Gores Lane, Formby
L37 3NU
Telephone: 01704 879430

www.thevillagesurgeryformby.nhs.uk
Fax: 01704 835052

Please read this carefully before filling in the form:

To help us to locate your medical records please complete the form as fully as you can.
It can take 5-7 working days for your registration to be complete.
If you require medication during this time you will need to go back to your previous practice unless you have evidence of your medication.
We have shaded grey the boxes which we require to be able to proceed with the registration.
Failure to complete these fields could result in your registration being delayed.

We also require TWO forms of identification from the following list, which verify the registration address and family name. Please do not hand in original documents, photocopies only

* Bank card / credit card	* Recent correspondence from a government body
* National Insurance / NHS number card	* Birth certificate
* Recent bank statement / utility bill	* For patients from overseas – a passport or ID card
Surname: **Title:**	**Forenames** (underline the name which you are known by)
Previous Names:	**Male / Female**
Date of Birth:	**Place of Birth:**
Home Tel:	
Mobile Number: (By providing us with this you are giving us consent to send text messages)	**Email address:** (By providing us with this you are giving us consent to send email messages)

Home Address:

Is this the first time you have registered with a GP in the UK? **YES / NO** (please circle as appropriate)

If you are returning from abroad please provide date of leaving:
If you are moving here for the first time please give the date you first came to live in the UK:

Previous Address in UK:
If possible please provide us with the last 2-3 addresses if you have moved several times in the past few years

1	2	3

Ethnic Origin: (Please tick the appropriate box)

White British	Other White ethnic group	Black African	Black Caribbean
Black Other Mixed	Chinese	Indian	Other: (Please specify)

Main Language:

Previous GP Name & Address

Name of Next of Kin:
Relationship to you:
Next of kin telephone number:
Are they registered at this practice?

DATA SHARING : PATIENT OPTIONS

Summary Care Record (SCR)

This allows health & care staff, such as district nurses, mental health practitioners etc., (away from your GP Practice) who are involved in delivering care to you, to view information in your records. It will give them better medical information when they are treating you.

Your options are outlined below; please indicate your choice:

a) ☐ Express consent for medication, allergies and adverse reactions only.

b) ☐ Express consent for medication, allergies, adverse reactions and additional information.

This includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

c) ☐ 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 do not complete this section, option b (above) will be automatically applied**

***You are free to change your decision at any time**

Type 1 Opt-Out

Data from GP records can be shared with NHS digital.

If you do not want your GP data to be shared with NHS Digital you can opt out by ticking this box ☐

(For information on which data is shared please visit our website www.thevillagesurgeryformby.nhs.uk)

***You are free to change your decision at any time** *** This decision will not affect your individual care.**

Type 2 Opt-Out (National data opt-out)

Data held by NHS Digital can be shared for purposes beyond your direct care such as used for research & planning.

You can update your preference for sharing data for the National Data Opt-Out by visiting our website at www.thevillagesurgeryformby.nhs.uk where there is more information and a link to an NHS digital online form.

***You are free to change your decision at any time** *** This decision will not affect your individual care.**

Nominate Pharmacy: Please indicate here which pharmacy you would like your prescription to go to. If you do not nominate a pharmacy it may delay your first medication issue.

The next section only needs to be completed if you are over 16 years: About You:

Are you a carer? ☐ **Yes** ☐ **No**

Is the person you care for at this surgery? ☐ **Yes** ☐ **No.**

If you answered YES please state Name____________________________ **Date of Birth**________________

Do you have a carer? ☐ **Yes** ☐ **No**

Carer's Name____________________ **Carer's Phone Number**____________________________

Are they a patient at the practice? ☐ **Yes** ☐ **No**

Height:________________ Weight:________________	Do you smoke? ☐ Yes ☐ No If YES how much per week?______ Did you ever smoke? ☐ Yes ☐ No If yes, when did you give up?______	Do you drink alcohol? ☐ Yes ☐ No If YES how much per week
Do you exercise? ☐ Yes ☐ No How many times per week?________	**We can offer advice to help to stop drinking or smoking. Please see our website for further details**	

For staff use only: Please tick which item you have seen:

Bank card / credit card		**Name**
National Insurance statement / card		
Recent bank statement / utility bill		
Recent correspondence from a government body		**Signature**
For patients from overseas – a passport or ID card		
Birth certificate		