NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

First names .....

Date of Birth

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 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 .....

Version 01/02

Please see right re: Organ donation

NHS GSM1

I would like to join the NHS Organ Donation 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

.....

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

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give blood.

Tick here if you have given blood in the last 3 years ☐

.....

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 your 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

.....

☐ 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.

Authorise Signature

Name

Date

Practice Stamp

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

Patient Additional Information

Please fill in all the sections below using BLOCK CAPITALS

Middleton Health Centre

Home tel | | | | | | | | | | | Mobile | | | | | | | | | | |

Ethnic Origin

☐ British or Mixed British ☐ Irish ☐ Other White ☐ Bangladeshi ☐ Indian ☐ Pakistani

☐ Black African ☐ Black Caribbean ☐ Other Black ☐ Chinese

☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean

☐ Other (please specify) _____ ☐ Rather not say

Spoken Language

Do you need a translator? ☐ YES ☐ NO

Are you registered disabled? ☐ YES ☐ NO

Are you a registered carer? ☐ YES ☐ NO

Do you smoke? ☐ Never smoked tobacco ☐ Ex-smoker _____a day ☐ Current smoker _____a day

If you smoke would you like help to quit? ☐ YES ☐ NO

Would you like to be able to book appointments and order prescriptions online? ☐ YES ☐ NO

If yes, please provide an email address (Please note; we will not share this email address with any external organisations)

Next of kin name

Next of kin phone number

Your relationship with them

If you are aged 15 -24 and would like an RUclear Chlamydia test, please ask the Nurse at your health check appointment.

Please note that we cannot register you, unless proof of address and ID are provided

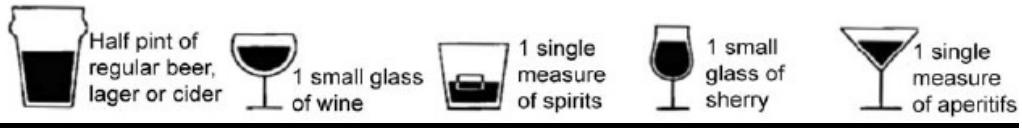
☐ Passport **or** ☐ Birth Certificate **or** ☐ Driving Licence

AND

☐ Bank Statement **or** ☐ Utility bill **or** ☐ Council Tax Statement

If you have any questions or need any help please call the surgery on **0161 655 7434**

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing 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 drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS), GP practice staff, visit the website or www.nhscarerecords.nhs.uk or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no Date .....

Ref: 4705