NHS

Family doctor services registration *GMS 1*

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 surnames

☐ 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 the 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 the 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*

☐ 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

What is your ethnic group? Please tick ONE box only.

☐ White British ☐ White Irish
☐ Any other White background - please write details here:_____

☐ Mixed White and Black Caribbean ☐ Mixed White and Black African ☐ Mixed White and Asian
☐ Any other mixed background - please write details here:_____

☐ Asian or Asian British: Indian ☐ Asian or Asian British: Pakistani ☐ Asian or Asian British: Bangladeshi
☐ Any other Asian or Asian British background - please write details here:_____

☐ Black or Black British: Caribbean ☐ Black or Black British: African
☐ Any other Black or Black British background - please write details here:_____

☐ Chinese
☐ Any other ethnic group - please write details here:_____

☐ Signature of patient ☐ Signature on behalf of patient — Date

Please see overleaf for Organ donation

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 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 0845 60 60 400

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 includsion 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 overleaf, eg your place of work)

_____ Postcode _____

To be completed by the doctor

Doctor's 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 name below who is a member of this practice

Doctor's 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 and will provide Child Health Surveillance to this patient

Doctor's Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority 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 ou 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

Practice Stamp

Authorised Signature

Name *Date*

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