# 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

Email Address

## 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**

# NHS Family doctor services registration

GMS1

## 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 | |
| *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.* | 7: Identification number of the institution | |
| | 8: Identification number of the card | |
| | 9: Expiry Date | DD MM YYYY |
| 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.

# The Mansell Road Practice

## *Registration Questionnaire*

**You now have a named GP. If your surname starts with A-K then your named GP is Dr Stapleton; L-Z its Dr Sivanesan.**

### Please complete all sections of the form

*Incomplete or unreadable forms can delay your registration so please ensure your answers are legible.*

## PLEASE COMPLETE ALL BOXES

| | |
|---|---|
| **1.0 First Language** | |
| **1.1 Do you need or experience any of the following?** (please tick) | ☐ No<br>☐ Interpreter (language)<br>☐ Sight impaired<br>☐ Hearing impairment<br>☐ Has difficulty with speech<br>☐ Other – please write: _____ |
| **1.2 Allergies** | List.. |
| **1.3 Do you live in a residential or nursing home?** (please tick) | ☐ Yes<br>☐ No |
| **1.4 Are you a Carer? (**Admin- add code Ub1ju**)** (please tick)<br>NB. A carer is somebody who looks after friends or relations who need support due to frailty, disability or a serious health condition. | ☐ Yes<br>☐ No |
| **2.0 Your Local Pharmacist Address:** (Where you can pick up your prescription medication from) | |
| **3.0 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<br>☐ Yes<br>☐ No |

**4.0 Your ethnic background** – please tick the appropriate box

| | | | |
|---|---|---|---|
| White British ☐ | Black African ☐ | Indian ☐ | Any other ethnic ☐ background – please state: |
| White Irish ☐ | Black Caribbean ☐ | Pakistani ☐ | |
| White – Other ☐<br>Please State: | Black - Mixed ☐ | Arab ☐ | |
| | | Asian – Other ☐<br>Please State: | |

## CONTACTING YOU

**4.0** We are able to contact patients by email and / or text. If you would like us to contact you in this way. We also need to know if you are happy for us to leave messages on your answer phone if we need to get in touch with you.

| | |
|---|---|
| **(a) Are you happy for us to contact you by email?** (please tick) | ☐ Yes<br>☐ No |
| **(b) Are you happy for us to contact you by text?** (please tick) | ☐ Yes<br>☐ No |
| **(c) Are you happy for us to leave messages for you on your answer phone?** (please tick) | ☐ Yes<br>☐ No |
| **(d) Aged 16+**<br>**Would you like to book appointments, request repeat prescriptions and be able to view a summary of your medical records on-line?** (please tick)<br>(bring ID to surgery after registration confirmed to set up) | ☐ Yes<br>☐ No |

## Sharing your medical records with others

The NHS would like to share your data with others in a number of ways. Please answer the questions below so that we know how you wish us to share your data.

**5.1 Summary care records – Sharing In** (www.nhscarerecords.nhs.uk)

Mansell Road Practice is a part of the national Summary Care Record program. This enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS spine. The summary record can be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline.

**Please indicate below whether you would like to have your own Summary Care Record by indicating your decision below** (please tick the appropriate box**):**

☐ I wish to have a Summary Care Record containing my medications allergies and adverse reactions or sensitivities to medications

☐ **I** wish to have a Summary Care record with the above **plus** additional important medical information held on my record

☐ **I** do not wish to have a Summary Care Record (Warning: This will slow down access to your records in emergencies)

**5.2 Sharing your records with other community health and social care teams – Sharing Out**

We often work with other clinicians such as district nurses, community midwives, community matrons, health visitors, social services, palliative care. These teams are not employed by our practice but they may need access to your records to support you appropriately. They abide by all of our rules around patient confidentiality.

**Are you happy for us to share your records with the community teams that we work with to provide your health support?** (please tick the appropriate box)

☐ Yes

☐ No

## NEXT OF KIN DETAILS

| | |
|---|---|
| **6.1 TITLE - Mr/ Mrs / Miss / Ms** | |
| **6.2 Next of kin First Name** | |
| **6.3 Next of kin Surname** | |
| **6.4 Address** | |
| **6.5 Post Code** | |
| **6.6 Contact Number/s** | |
| **6.7 Is your next of kin your emergency contact** (please tick) | ☐ Yes<br>☐ No |
| **6.8 Can we discuss your medical record with your next of kin?** (please tick) | ☐ Yes<br>☐ No |
| **6.9 Is your next of kin registered at this practice?** (please tick) | ☐ Yes<br>☐ No |
| **6.10 How is your next of kin related to you?** | |
| | |

## DO YOU SMOKE

please tick the appropriate boxes next to the options

☐**I have never smoked**

☐**I used to smoke** (write the date you stopped and how many cigarettes you smoked……)

☐**I am a current smoker** (please write in how many cigarettes you smoke in a day……..……..)

**If you would like help to stop smoking** please call: One You Ealing 08008766683

## HOW MUCH ALCOHOL DO YOU DRINK

- please tick the appropriate boxes

| | | | | | |
|---|---|---|---|---|---|
| **8.1 How often do you have a drink that contains alcohol?** | **Never ☐** | **Monthly or less ☐** | **2 - 4 times per month ☐** | **2 - 3 times per week ☐** | **4 + times per week ☐** |
| **8.2 How many standard alcoholic units do you have on a typical day when you are drinking? (1 pint =2 units minimum)** | **1 - 2 ☐** | **3 - 4 ☐** | **5 - 6 ☐** | **7 - 9 ☐** | **10 + ☐** |
| **8.3 How often do you have 6 or more standard drinks on one occasion?** | **Never ☐** | **Less than monthly ☐** | **Monthly ☐** | **Weekly ☐** | **Daily or almost daily ☐** |

## Catchment Area & Deductions (Removals)

**9.1. I understand that if my address is outside the catchment area for The Mansell Road Practice, I will not be visited at home.** (Admin- add code XaZ4g if outside)

**9.2 I understand that it is my responsibility to arrive for appointments on time and that persistently missing/arriving late for appointments will lead to my deduction (removal from The Mansell Road Practice).**

**9.3 I understand that it can take up to two weeks for my registration form to be processed; longer if this is the first time I am registering with the NHS.**

**9.4 I understand that If I don't want my data shared I need to opt out, details at - https://digital.nhs.uk/services/national-data-opt-out**

| | | | |
|---|---|---|---|
| **Signature** | | **Date** | |

# Addition Child Required Answers

| | |
|---|---|
| **School Name** | |
| **School Address** | |
| **Has the child had:** Whooping Cough (please tick) | ☐ Yes ☐ No |
| **Has the child had:** Rubella (please tick) | ☐ Yes ☐ No |
| **Has the child had:** Measles (please tick) | ☐ Yes ☐ No |
| **Has the child had:** German Measles (please tick) | ☐ Yes ☐ No |
| **Has the child had:** Mumps (please tick) | ☐ Yes ☐ No |
| **Has the child had:** Chicken Pox (please tick) | ☐ Yes ☐ No |
| **Does the Child take any current medication:** List Names and Dosage | |
| **Is the Child Allergic to anything** (please tick) | ☐ Yes ☐ No |
| **Allergies:** list | |
| **VACCINATION** | **Has the child had the following recommended vaccinations?** |
| **At birth:** BCG | ☐ Yes ☐ No |
| **8 weeks:** Diphtheria/ Tetanus/ Polio/ Hib and PCV Pertussis, Hep B, Men B Rotavirus (GP/CLINIC) | ☐ Yes ☐ No |
| **12 weeks:** Diphtheria/ Tetanus/ Pertussis/ Polio/ HIB and Meningitis, Hep B, Rotavirus C (GP/CLINIC) | ☐ Yes ☐ No |
| **16 weeks:** Diphtheria/ Tetanus Pertussis/ Polio/ HIB Meningitis B Hep B PCV (GP/CLINIC) | ☐ Yes ☐ No |
| **12 months:** HIB/ MenC booster MMR Pneumococcal (GP/Clinic) | ☐ Yes ☐ No |
| **3 years and 4 months:** Diphtheria/ Tetanus/ Pertussis/ Polio – MMR (GP/CLINIC) | ☐ Yes ☐ No |
| **Girls 12-13 years:** HPV - @ school | ☐ Yes ☐ No |
| **14 years old:** Tetanus Diphtheria Polio Meningococcal ACWY | ☐ Yes ☐ No |

**IF YOU HAVE COME FROM ABROAD PLEASE MAKE AN APPOINJTMENT WITH OUR PRACTICE NURSE TO MAKE SURE THAT YOUR CHILD IS UP-TO-DATE WITH THEIR IMMUNISATIONS.**