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

NHS Family doctor services registration

GMS1

GMS1_112018_005 Family Doctor Services Registration_tearoff.indd 1 27/06/2019 15:08

Practice Stamp

Authorised Signature

Name Date _____/_____/_____

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

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.

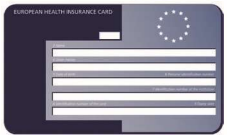
A parent/guardian should complete the form on behalf of a child under 16.

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

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.

Victoria SURGERY

New Patient Registration Form

Thank you for choosing to register with Victoria Surgery.

Please fully complete this questionnaire, writing clearly and in BLOCK CAPITALS. If you require any assistance, please speak to Reception.

In order to speed up the registration process, please provide Reception with photographic ID and evidence of your address (such as a utility bill) at the time of handing in your registration forms if these documents are available. If you do not have these documents, you are still able to register with our Practice.

Full Name:		Date of Birth:
Address: Postcode:		
Home Phone Number:	Mobile Phone Number:	Work Phone Number:
Email Address:		
Consent to contact you via email: Yes ☐ No ☐		Consent to contact you via text message: Yes ☐ No ☐
NHS Number:		Place of Birth:
Relationship Status:		Occupation:
Ethnicity:		
Main spoken language:		Translator required? Yes ☐ No ☐
Armed Forces Veteran		Yes/No
Do you have any communication, or building access needs? Yes ☐ No ☐		If yes, please provide details to reception
Next of Kin Name and Address:		Relationship to you: Contact Telephone Number:
This person is able to discuss my health records		Yes or No
Are you a carer? Yes ☐ No ☐		If you spend time looking after a relative, child, partner or friend who is disabled or has a mental health difficulty, you are a carer

Does someone care for you? Yes ☐ No ☐	If yes, who cares for you?
Are you housebound? Yes ☐ No ☐	Would you like to hear from other organisations that can support you? Yes ☐ No ☐

Medical History

Do you suffer from any of the following (please tick)

Asthma		**Please List Any Allergies Below**
COPD		
Diabetes Type 1		
Diabetes Type 2		
Epilepsy		
Dementia		
Hypertension		
Heart Failure		
Hypothyroidism		
Stroke		
Any other Condition (please list opposite		

Family Medical History (please tick)

Diabetes	
Stroke	
Asthma	
Heart Disease (CHD /IHD)	
Cancer	
High Blood Pressure	
Any other (please list)	

Are you taking any medications?

Please List below or attach a prescription counterfoil

Name of Medicine	**Dose**
Please State the name of your nominated Pharmacy	

Smoking status – Are you: **A current smoker ☐** **An ex-smoker ☐** **A non-smoker ☐**	If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker, please give the date you stopped (month/year).
Smoking cessation advice is available. Would you like further information?	If yes, please ask at reception or see our website for details.

Alcohol scoring system	0	1	2	3	4	Score
How often do you drink 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 drinking?	1-2	3-4	5-6	7-9	10+	
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Never	Less often than monthly	Monthly	Weekly	Daily or almost daily	
Advice is available if you would like to reduce your alcohol intake.	Please ask at reception or see our website for details.					

Females only:	
Are you currently Pregnant	
Have you had a hysterectomy	Please provide date
Date of last cervical smear	

Patient Participation Group

The practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views and ideas for making services better. By expressing your interest, you will helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date developments within the practice.

If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you.

Yes I am interested in becoming involved in the PPG (please tick the 'Yes' box)	Yes	

Consent To Hold Your Records

The Practice needs to hold your medical records on the premises in order to give you the best medical care possible. We keep your records on the computer as well as holding paper notes. All of our patient's notes are covered by the Data Protection Act 2018. This means that a third party cannot access your records without your consent.

Summary Care Record

Your Summary Care record is an electronic record of important information about your health and is available to healthcare staff providing your NHS care in England, for example A&E. This means that if you ever become ill and need urgent or out of hours treatment outside of the surgery, the clinicians that treat you will have immediate access to important healthcare information about you. If you do not want this to happen, please ask reception for an Opt-Out form

PATIENT DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check.

Information on the services we provide is available in the Practice Leaflet or via our website

www.victoriasurgery.co.uk

Application for Online Services

Please return this form along with **photographic ID and proof of address** to the surgery
OR you can also arrange access via the NHS App on a smartphone

SURNAME:	FIRST NAME:
DATE OF BIRTH:	
ADDRESS:	
EMAIL ADDRESS (PATIENT OR PROXY):	
TELEPHONE NO:	MOBILE NO:

NAME OF PROXY (IF APPLICABLE): D.O.B OF PROXY:	SIGNATURE OF PROXY (IF APPLICABLE):	RELATIONSHIP TO PATIENT:

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

If we grant you online access is there the possibility that someone else may access your record without your permission or against your wishes (coercion), (please tick): YES ☐ NO ☐ **I wish to access the online services, and understand and agree with each statement (please tick):**

1. I have read and understood the information leaflet provided by the practice	☐
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:**

Please return your completed form **with photographic ID and proof of address** to:
Victoria Surgery, Victoria Street, Bury St Edmunds, IP33 3BB

FOR PRACTICE USE ONLY

<table>
<tr><td>NHS NUMBER:</td><td colspan="2"></td></tr>
<tr><td>IDENTITY VERIFIED BY:

_____

AUTHORISED BY:

_____

DATE: _____</td><td>DATE:</td><td>METHOD (please tick):

VOUCHING ☐

VOUCHING WITH INFORMATION IN RECORD ☐

PHOTO ID AND PROOF OF RESIDENCE ☐</td></tr>
<tr><td>DATE ACCOUNT CREATED:</td><td colspan="2"></td></tr>
<tr><td>DATE PASSPHRASE GIVEN:</td><td colspan="2"></td></tr>
<tr><td colspan="3">NOTES/EXPLANATION:

CHECK DATE ☐</td></tr>
</table>

Information for new patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that 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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

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

or

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

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of Patient: ……

Address: ……

Postcode: …… Date of Birth: ……

NHS Number (if known): ……

Signature: …… Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.