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 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*

**Not all doctors are authorised 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

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Please see overleaf re: Organ donation

NHS 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

Lyn Health

New Patient (Child 0-16yrs) Questionnaire

Please complete all the following and hand back to the receptionist.

Date: _____

Full Name: _____

Date of Birth: _____ Telephone Number: _____

Mobile No: _____ ☐ Please tick the box. If you **do not** consent for us to use your mobile number for text messaging, appointment reminders, questionnaires & other health promotion messages.

Address: _____

_____

Mothers Name _____ Mothers DOB _____

Fathers Name _____ Fathers DOB _____

Lynton Chemist will be allocated as your nominated dispensary unless you notify us otherwise.

Which of the following best describes your ethnic origin?

Decline to say		**Mixed**		**Asian or Asian British**	
White		White and Black Caribbean		Indian	
British		White and Black African		Pakistani	
Irish		White and Black Asian		Bangladeshi	
Other, please state		Other, please state		Other, Please state	
Black or Black British		**Chinese or other ethnic group**			
Caribbean		Chinese			
African		Other, please state			
Other, please state					

What is your main spoken language _____

Having read the Summary Care Information Sheet and Data Sharing Leaflet please place a cross (X) in the boxes if you want to **OPT OUT** of any of the following:

Summary Care Record – This is a summary of your **medication, allergies and adverse reactions** and can only be access by a **clinician in England** and with your **expressed consent**. ☐

Local Health Record – This allows access to your **FULL** Health Record to **Out of Hours Service** and **Secondary Care in Devon ONLY** and with your **express consent** at the point of care. ☐

Care.Data – The care.data programme will bring together securely, health and social care information from different settings in order to see what's working really well in the NHS and what could be done better. This is not accessible to clinicians and **WILL NOT** help with your care it is for statistical purposes only. ☐

If there are any health problems that run in your family or any other information you feel it is important for us to know please make a note of this overleaf.

Please note if you are on any current medications or have any health problems for which you see a Doctor regularly, please book in to see a Doctor for your new patient check.

Signed: _____ **Date:** _____

Lyn Health

New Patient Questionnaire – Additional Information

Health Visitor /School Nurse Notification Form

This information will be passed to the Public Health Nursing Team so that they can request your child's previous notes. A member of the team will contact you to provide support and local information that might be useful to you.

Family Details

PREVIOUS DETAILS	PRESENT DETAILS
Address	Address
Postcode	Postcode
	Telephone Number:
	Mobile Number:
GP Name & Practice	GP Name and Practice

Individual Details – all children under 16 please

Name	Date of birth	Male / Female	School Attending (if applicable)	Previous School

CARERS IDENTIFICATION AND REFERRAL FORM

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?

If so, you are a carer and we would like to support you. Please complete this form and hand it in to reception.

If you are agreeable, we will pass your details to Devon Carers, which is part of a countywide organisation providing relevant information and advice, local support services, newsletter and telephone linkline for carers.

We will also refer you, with your permission, to have your needs assessed by Adult Care Services. A Carers Assessment is a chance to talk about your needs as a carer and the possible ways help could be given. It can also look at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

YOUR DETAILS:

Name	
Date Of Birth	
Address Post Code	
Telephone Number	
Any relevant Information	

DETAILS OF THE PERSON YOU LOOK AFTER:

Name	
Date Of Birth	
Address (If Different From Above) Post Code	
Telephone Number (If Different From Above)	
GP Details (If Different From Your Own)	

☐ Please pass my details to Devon Carers.

☐ Please refer me to Adult Social Care Services.

For internal use only - Please pass to Admin Team for Action

For Usual GP - Reviewed to confirm that patient is competent to give a valid informed consent	**YES**	**NO**	**Inits**	**Date**
Computer record updated (Tick code used and enter Sig /Active)	**Carer – 918A**	**Has a Carer – 918F**	**Inits**	**Date**

CONSENT FOR A CARER TO HAVE ACCESS TO A PATIENT'S PERSONAL DETAILS AND/OR COPIES OF CORRESPONDENCE

Patient's Name	
Patient's Address	

To: **Lyn Health**

I give permission for my Carer
..... to have access to my medical records and personal details held by the Practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

I consent to my Carer receiving copies of all correspondence relating to my treatment (*delete if not applicable*). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed_____(Patient)

Date _____

Accepted by_____(Doctor)

Date _____

Office Use Only:	Date	Actioned (Tick)	Initials
Major Alert entered on SYSTEM ONE			
Copy Scanned			
Original Document filed in Lloyd George Notes			