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 ___/___/___

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:

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

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NHS Family doctor services registration

GMS1

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

SUPPLEMENTARY QUESTIONS

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	
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.	**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.

LYN Health
Medical and Minor Injury Services

New Patient (Child 0-14yrs) Questionnaire

Please complete in BLOCK CAPITALS 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.

Email Address: _____ ☐ Please tick the box. If you **do not** consent for us to use your Email address, 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. ☐

Continued Overleaf...

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 your child is on any current medications or has any health problems for which they see a Doctor regularly, please book in to see a Doctor for your new patient check.

Signed(Parent or Guardian):_____ **Date:** _____

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

LYN Health
Medical and Minor Injury Services

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			