

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and ✓ as appropriate

Mr Mrs Miss Ms Surname _____
 Date of birth ____/____/____ First names _____
 NHS Number ____/____/____ Town & country of birth _____
 Male Female Norwich Address _____

Post Code _____ 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 doctor while at that address _____

Post code _____

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 and appliances*

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*

Signature of patient Signature on behalf of patient Date _____

Please see overleaf re: Organ donation

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NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissues may be used for transplantation after my death. Please tick the boxes that apply.

Any of my organs and tissues 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 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 the above, eg. 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 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 the 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 _____ Practice Stamp _____

HA use only Patient registered for: GMS CHS Dispensing Rural practice