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 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________/_________/_________

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

042017_003 Product Code: **GMS1**

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

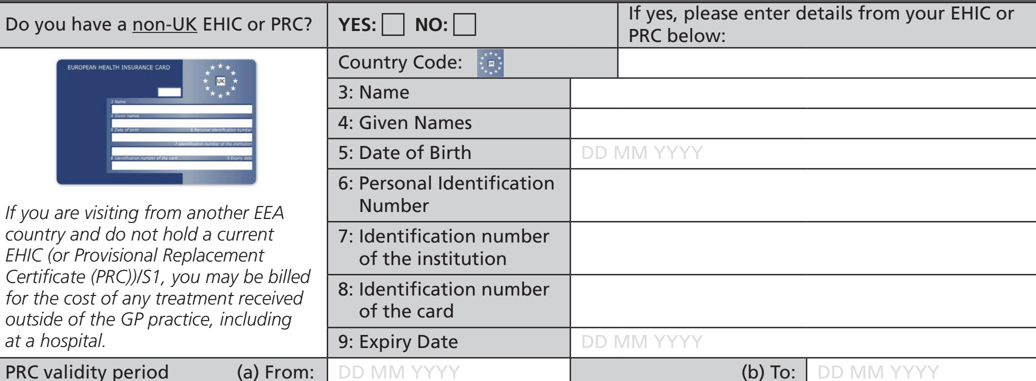
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:
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.	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

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.

GMS1_072017_004 Family Doctor Services Registration_tearoff.indd 2 20/07/2017 14:27

Mayfield Medical Centre
New Patient Questionnaire
For under 5's

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other …………………………………………………………………………

Surname……………………… First Name(s)…………………………………

Date of birth…………………………………

Place of birth (Town/Country)………………………………

First Language………………………
Do you require an interpreter? ☐ Yes ☐ No
If so please provide contact details for someone who can speak English should we need to get a message to you by phone. Tel…………………………

Please tick the box which best describes your Ethnic Origin.			
White British	☐	Black British	☐
White Other	☐	Black African	☐
		Black Caribbean	☐
Mixed Black African and White	☐	Black other mixed	☐
Mixed Black Caribbean and White	☐	Black other non mixed	☐
Asian British	☐	Chinese	☐
Indian	☐	Bangladeshi	☐
Pakistani	☐	Other Asian Ethnic Group	☐

Please give details of the next of Kin and/or the details of the carer for the child.
Name………………………Address………………………………………………...
………………………………………………………………………………………..
Tel No………………………………Relationship to child………………………

Are all childhood immunisations up to date for this child? ☐ Yes ☐ No

Thank you for completing this form.
<u>Please ensure that if you are on regular medication you request a month's supply from your current doctor as we are not able to issue medication before we have your records</u>.

Privacy Notice
To understand how we protect your data and what your data rights are, read the Patient Privacy Notice at www.mayfieldmedicalpractice.nhs.uk or ask reception for a copy. Any questions please direct to the Practice Manager.

Mayfield Medical Practice

Form 2 (Consent to use for reminders/health campaigns/contacts (if applicable))

Dear Patient

Occasionally, Mayfield Medical Practice would like to contact you with appointment reminders/health campaigns/services that we provide and test results.

If you consent to us using your contact details for this purpose, you have the right to modify or withdraw your consent at any time by using the opt-out/unsubscribe options or by contacting us directly.

If you consent to us contacting you with the above-mentioned services, please tick to say how you would like to be contacted: -

Text Message (SMS) ☐ (9NdP) Email ☐ (9NdS) Telephone ☐ (ESCTCO16) Post ☐ (EMISNQCO224)
You can modify or withdraw consent at any time, which we will act on immediately, unless there is a legitimate or legal reason for not doing so.

If you consent to us contacting you for the purposes stated above, please sign below and print your name: -

Patient signature……………………………………………………………………………………………………..

Print name……….

Date……

I wish to opt-out of appointment reminders/health campaigns/services that we provide and test results ☐ (9NdQ)

Reason for Opt Out If Appropriate………………………………………………………………………………..

………..

Patient signature……………………………………………………………………………………………………..

Print name……….

Date……

Form 4 (Consent to use online services (if applicable))

Online Services for ordering of repeat prescriptions, booking GP appointments and viewing your medical record securely

Once pre-registered with the online service, a pin number and password will be generated for you and this will need to be collected from the surgery to activate the service.

You will be required to prove your identity upon collection using a valid form of identification such as a passport, utility bill, photo driver's licence or other form of valid identification.

Only access will be given to order repeat medication for patients under the age of 16. If a parent or guardian registers on behalf of a patient that is under the age of 16 the service will automatically cease to function once the patient reaches 16 years of age. We reserve the right to cease access to a parent/guardian upon instruction from the patient.

Access to view your medical record online is only available to patients over the age of 18 unless otherwise agree by a senior doctor.

Access to view your medical record online can be granted to another individual or individuals with the exception of patients under the age of 18. Access will only be granted if agreed/authorised by a senior doctor and has been authorised by the patient.

If you wish the GP Practice to register you for these services please complete the details below, providing your telephone contact numbers, including the area code for your landline number.

Patient Name…….

Mobile telephone number…………………………………………………………………………………………..

Landline telephone number ………………………………………………………………………………………..

Email address…….

Disclaimer

If you agree to the GP Practice contacting you via your mobile phone or fixed land line number, the GP Practice agrees to adhere to the following:

1. The mobile phone number or fixed land line number will only be used by the GP Practice and will not be passed to any other parties.
2. If at any time you would like to opt out of either of the above services, please make a personal request to the GP Practice and you will be opted out of the service within 48 hours. You may also like to include your reason for opting out, to help us review and improve the service in future.
3. Your mobile phone number will solely be used by the GP Practice in relation to the healthcare services offered by the GP Practice. *You will not be contacted in relation to any other types of products or services.*
4. No personal details will be included in the message to identify you.
5. We reserve the right to cease access to any of the above additional services if you abuse the system as per the discretion of the senior doctor.

Patient signature………………………………………………………………………………………………………..

Date……

Reason for Opt-Out If Appropriate……………………………………………………………………………..

………..

………..

Staff Use Only

Age Verified	YES/NO	Age at Registration……………………………
Identification Verified	YES/NO	
Access to Medical Record Required?	YES/NO	

Name of Staff Member Verifying Identity……………………………………………………………………….

Signature of Staff Member…………………………………………………………………………………………….

Date………..

Date Paperwork Collected……………………………………………………………………………………………

Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care. The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record - please see a member of the GP practice staff who will ask you to complete an opt out form.**

If you need more time to make your choice you should let your GP Practice know. For more information talk to our Patient Advice and Liaison Service (PALS) **(01902 445378),** GP practice staff, visit the website (**http://www.wolvespct.nhs.uk/**) or **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0845 603 8510.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0845 603 8510.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Practice Manager