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

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.

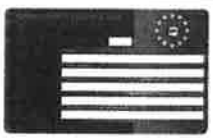
A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	
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: S	
	3: Name	
	4: Given Names	
	5: Date of Birth	
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	
PRC validity period (a) From:		(b) To:



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.

Dr. M. RAJARATNAM
Dr. GWEN McDOWALL
Dr. R. C.W. LAVELLE.
Dr. RACHEL KINSLER
Dr RACHEL WILLIAMS
Dr JENNIFER BARRETT

LISTER HOUSE
THE COMMON
HATFIELD
HERTFORDSHIRE
AL10 0NL

TELEPHONE No.
01707 283450
FACSIMILE No.
001707 270186

Welcome to Lister House Surgery

Registering As a patient at Lister House Surgery

Thank you for your interest in registering with our Practice. To ensure your registration process runs smoothly, you need to:

a. Complete a registration GMS1 form
b. Complete a practice New Patient Questionnaire form
c. Bring in proof of ID (passport or driving licence)
d. Bring in (1X) proof of address (i.e. council tax, utility bill, bank/building society cards/statements, local authority rent card, payslip, letter from Benefits Agency/benefit book/signing on card).

We can only accept patients who live in the Practice catchment area

You will be asked to supply proof of 1 photo ID (passport/ driving licence) and recent proof of address such as a utility bill, bank statement, council tax bill, etc. Any document provided should show your name and current address in the area, and be dated **within the last 3 months**.

You need to completed new patients forms

- Please complete a New Patient Questionnaire form and hand it in with your proof of address/ID
- Parents/guardians registering children under five years must provide details of all previous immunisations for each child.

Online Access

- You will be automatically enrolled for online access and SMS text messaging services at the practice at the point of registering with the practice.
- We will generate a username and password for you with instructions of how to access this. You must come back to reception to collect these details. Please allow at least 7 days for this. Online access* allows you to book appointments, order prescriptions online. You should advise the receptionist if you do not wish to have online access or SMS services.

Appointment Cancellations

- If you cannot attend an appointment please cancel it as soon as possible by contacting the Practice
- As by our practice policies, we do sometimes remove patients who persistently fail to attend booked appointments without cancellation.

Out Of Hours

- If you require a Doctor out of hours, please call NHS **111 (dial 111)**; you will be advised on the best course of action.

Please read our Practice booklet or visit our website at www.listerhouse.nhs.uk to keep up to date.

Lister House Surgery strongly supports the NHS Zero Tolerance policy; any abusive or threatening behaviour towards any member or our team or other patients, will result in removal from our list. This includes verbal abuse and aggressive language.

We look forward to welcoming you to the Practice.

*If you wish to see your full medical records you must put this in writing to practice manager.

Lister House Surgery New patient Questionnaire (under 16 years old)

[At least one parent/guardian needs to be registered at the Practice]

PLEASE WRITE IN BLOCK CAPITALS

PERSONAL INFORMATION

Your First Name:.....Surname.....

Relationship to the child:.....

Child Date of Birth: ..... Gender: M / F

First Names: ..... Surname: .....

Address: .....

Telephone Number:
Home: ..... Mobile: .....

Area & Town of Birth (if in UK).....

Country of Birth (if not UK).....

If from overseas, when did you enter the country ?.....

Mother's name: .....DoB.....

Address if different from the child.....

Father's name:.....DoB.....

Address if different from the child.....

Siblings: .....DoB.....

.....DoB.....

.....DoB.....

Name and relationship to the child of any other household members:

.....

.....

Parent/Guardian registered at LHS.....

Primary Carer.....

Who has parental responsibility?.....

(Note – It is always the mother and also the father if parents married when/since the child was born or for children born in England and Wales after 1st December 2003, also the father if on the Birth Certificate. Father doesn't lose Parental Responsibility after divorce)

Name and Address of present school or nursery

.....

Previous GP – please give details

.....

Current Social Worker **Yes ☐ No ☐**
If *Yes*, give their name and address (which borough if address not known)
.....
.....
.....

Previous Social Worker **Yes ☐ No ☐**
If *Yes*, give their name and address (which borough if address not known)
.....
.....
.....

Is the child in a care home or fostered? **Yes ☐ No ☐**
.....

HEALTH INFORMATION

Is the child being treated for any medical problems, e.g: Asthma, Diabetes or any other condition? Yes ☐ No ☐
If Yes, *give details*.....

Has any disabilities Yes ☐ No ☐
If Yes, *give details*.....

Had any operations Yes ☐ No ☐
If Yes, *give details*.....

Has any allergies Yes ☐ No ☐
If Yes, *give details*.....

Is the child under hospital treatment for any condition? **Yes ☐ No ☐**
If Yes, *please state dates and reasons*.....
.....

Has the child attended A&E in the last 2 years? **Yes ☐ No ☐**
If Yes, *please state dates and reasons*.....

.....

Is the child on regular medication? **Yes ☐ No ☐**
If ***Yes****, give details:*.....
.....

If the child is on long term medication for any medical condition you will initially need to see a doctor to obtain a prescription.

Ethnicity

White British / Irish / Greek Cypriot / Turkish / Kurdish/ Polish / Other please specify ……	**Asian** Indian / Pakistani / Bangladeshi / East African Other please specify:……
Black Caribbean / African / Black British/ Other please specify:……	**Mixed** White & black Caribbean / white & black African /white & Asian / Other please specify:…… …
Chinese Chinese / Other please specify ……	**Other** Other please specify:……

What is your religion? (circle one answer)

Buddhists/ Christian / Hindu / Jewish/ Muslim/ Sikh/ None / Other (please specify)……..

What is your main spoken language? (circle one answer)

English/ Bengali/ Polish/ Guajarati/ Hindu/ Punjabi / Patois/ creole/ French/ Italian/ Spanish/ Any other language please specify……..

How well do you speak English?

Very well/ Fairly well/ slightly / Not at all

Do you have difficulties communicating? Yes ☐ No ☐ If **yes** what is your preferred method of communication? Please specify ……

What is your height (either)	cms	(or)	ft& ins
What is your weight (either)	kgs	(or)	st &lbs

SMOKING (children aged 14-16 only)

Current Smoker: Yes ☐ No ☐ Amount per day…… Cigars/ Cigarettes/ Tobacco.

Never smoked: Yes ☐ No ☐

Ex-smoker: Yes ☐ No ☐ Date stopped smoking…

Childhood Immunisations

Please bring the red book or (only if you don't have one) please fill in below.

Do you agree to immunise the child? Agree ☐ Refuse ☐

Signature……Date……

Childhood Immunisations Record
at 2 months old:
1st DTP/Pert, Hib, 1st Pneumococcal, Rotavirus
Date given:
Place given:
At 3 months old:
2nd DTP/Pert, Hib & 1st Meningitis C, Rotavirus
Date given:
Place given:
at 4 months old
3rd DTP/Pert, Hib and 2nd Pneumococcal
Date given:
Place given:
at 12/13 months
Boosters Hib & Meningitis C
Date given:
Place given:
at 12/13 months
MMR & 3rd Pneumococcal
Date given:
Place given:
at 3½ to 4 years
Pre-School Booster
Date given:
Place given:
MMR Booster
Date given:
Place given:

For office use only

ANY CHILD WITH A 'YES' TO ANY OF THE QUESTIONS ASKED NEEDS TO HAVE A ROUTINE APPOINTMENT WITH A DOCTOR BOOKED AT REGISTRATION

Has the child been offered appointment with doctor? Yes ☐ No ☐

Has an appointment been made? Yes ☐ No ☐

If appointment booked please add a comment to the appointment slot stating the reason for the appointment as per the registration form.

Red Book Submitted and photocopy to nurse? Yes ☐ No ☐
Or
Child Immunisation Record Table completed Yes ☐ No ☐

Agrees to immunisation? Yes ☐ No ☐
If no, parent to sign the disclaimer form.

Has the identity and address been checked? Yes ☐ No ☐
Documents accepted (one only needed) - Tick which one
- Child benefit form Yes ☐ No ☐
- NHS card Yes ☐ No ☐
- Passport (for those who do not have document above)
Yes ☐ No ☐

Has Parental Responsibility been established? Yes ☐ No ☐
Documents accepted (only one needed) - Tick which one
- Birth certificate Yes ☐ No ☐
- Red book Yes ☐ No ☐
- Passport (If neither of the above available or born outside the country)
Yes ☐ No ☐

Please state who has parental responsibility:

.....

Who checked the form? (staff signature) .....date:.....

LISTER HOUSE SURGERY

SMS SERVICE CONSENT FORM

Lister House Surgery would like to offer you the ability to receive text messages from the practice. To do this we need your permission that we can contact you in this way, along with a valid mobile telephone number.

Communication by text could include:

- Reminders about appointments.
- Notifications to collect prescriptions or documents.
- Test results.
- Follow-up reminders about any annual reviews that we have written to you about and asked you to make an appointment for.
- Ad hoc messages containing personal sensitive medical information about you.
- Notifications with regards to cancelled appointments and unforeseen closures.
- Information about special clinics

If you would like to be contacted by text we will require your permission; either by completion of our consent form or responding to an electronic message sent from the Practice about text messaging.

We will not give your contact details to anybody else.

Your Responsibilities:

- The Practice does not accept responsibility for costs associated with downloading data we may send; e.g. links to videos.
- Please be aware that if you provide the Practice with false identification; e.g. not your details, then this could lead to legal/criminal proceedings.
- It is your responsibility to check your messages. In addition, if other people have access to your mobile phone then you need to decide if you are happy for them to see this information and if you have any doubts about the level of confidentiality that you can ensure then you should not use our text Messaging service.
- It is your responsibility to ensure we hold your up to date mobile number. (The Practice will not accept responsibility for text messages being sent to incorrect mobile numbers).
- Text messages (which could include links to health/educational videos may be sensitive to some people) are generated using a secure facility but you must understand that they are transmitted over a public network onto a personal telephone and as such full security is not guaranteed.
- If the Practice sends you a text/video link it is your responsibility to ensure that you read and understand the message sent.

These responsibilities are available to view on our website

Consent form for SMS/Text messaging

I confirm that I understand the above statement and that I am the patient listed below. If I decide that I no longer want to receive text messages then it is my responsibility to let the Surgery know.

Full Name	
Date of Birth	
Mobile Telephone Number	
Patient signature	
Date	
I **want** to receive text messages	☐
I **DO NOT** want to receive text messages	☐
Office use only	
Preference updated on system Y/N Initials:	

****YOU MUST LET US KNOW IF YOU CHANGE YOUR MOBILE NUMBER****

Please complete this form and return to the receptionist.

NHS Digital

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 who 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.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.
- **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

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

NHS Digital

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: .....

Date of birth: ..... Patient's postcode: .....

Surgery name: ..... Surgery location (Town): .....

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

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6