



## 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  FemaleTown 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 leavingDate you first came  
to live in UK

## If you are returning from the Armed Forces

Address before enlisting

Service or  
Personnel numberEnlistment  
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\*

*\*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 \_\_\_\_/\_\_\_\_/\_\_\_\_



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**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