NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

First names .....

Date of Birth

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 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 Surveillence

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 right re: Organ donation

I would like to join the NHS Organ Donation Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate.

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

.....

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to give blood.

Tick here if you have given blood in the last 3 years ☐

.....

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 your 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

.....

☐ 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.

Authorise Signature

Name Date

Practice Stamp

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

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no Date.....

THE MOUNTWOOD SURGERY

HEALTHY LIFESTYLE **SIDE A**

As part of the government's campaign on alcohol awareness, you are invited to fill in the following questionnaire.
Please select the appropriate column and add your score to the left – add your total to the bottom of the table.

Questions

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	Score
Score	**0**	**1**	**2**	**3**	**4**	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
Score	**0**	**1**	**2**	**3**	**4**	
How often have you had 6 or more units if female, or 8 or more if male on a single occasion in the last year	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	**0**	**1**	**2**	**3**	**4**	
					TOTAL	

A total of 5+ indicates increasing or higher risk drinking

If your score is over 5 please turn over and complete the rest of the sheet

Continued over

Side B

Insert total from side A

Total =

Please complete the remaining questions

How often in the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Total
Score	0	1	2	3	4	
How often in the last year have you filed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
How often in the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
Have you or somebody else been injured as a result of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Score	0	1	2	3	4	
					Total	

Side A Side B Total

Please add up your score from side A + B

Score analysis: 0-7 Lower risk, 8-15 Increasing risk, 16-19 Higher risk, 20+ Possible dependence

A TOTAL SCORE of 8 or above may indicate that you rare at some risk from alcohol related diseases and that you may fall into the category of hazardous drinking. If your score is 8 or above, you may be asked to make an appointment with Dr Pugh who is piloting this service.