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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km 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

Signature confirming my consent to join the NHS Organ Donor Register **Date** _____/_____/_____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register **Date** _____/_____/_____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

052019_006 Product Code: **GMS1**

The Cambridge Practice

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Please tell us about yourself:

Do you look after someone who could not manage without you? ☐ Yes ☐ No

Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?	Name of medication	What was the problem or upset?

Have you had a cervical smear test? ☐ Yes ☐ No If yes, what was the result? (if known)
Date (if known)

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state):
☐ Decline to state

Next of kin ……

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Title: Mr Mrs Miss Ms

Name: _____ Tel. contact number: _____

Relationship: _____

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, newsletter and the like

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

Email address

NHS App

You can download the NHS App all you need is photo I.D.
The features this app can offer is the ability to book appointments online check your symptoms and order repeat medication.
However we have an additional online access form which gives further access to your view medical history and check your test results.

Signature ……

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I confirm that the information I have provided is true to the best of my knowledge.

Signed: _____ Date: _____

Signature of patient ☐ Signature on behalf of patient ☐

Updated October 2019

ONLINE RECORD ACCESS ENROLMENT FORM

You can now use the internet to securely view your test results, your medical history, including current and past medication. Whether you want to improve your knowledge of your medical condition, or check your record for accuracy – it's at your fingertips when you need it. You can even access it from anywhere in the world if you need medical treatment on holiday.

By completing this form you are asking us to make information from GP records available to you, securely over the internet. Your information will not be made available without your permission. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

Things to Consider:

Although the chance of the following things happening is very small, please read and tick the boxes to confirm that you have understood:

1. Forgotten History -
There may be something you have forgotten about that could cause distress. ☐

2. Abnormal Results/Bad News -
You may see this before you have spoken to the doctor, or while the surgery is closed and you cannot contact them. ☐

3. Coercion -
If you think you will be pressured into revealing details from within your record to someone else, against your will, please reconsider using this service. ☐

4. Errors in your Record -
In this case please contact the Surgery to enable us to correct your record. ☐

5. NHS App -
Have you downloaded and accessed the NHS app. ☐

PLEASE COMPLETE IN BLOCK CAPITALS

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SURNAME	
FIRST NAME	
DATE OF BIRTH	
ADDRESS	
POST CODE	
EMAIL ADDRESS	
TELEPHONE NUMBER	

I wish to access my medical record online and understand and agree with each statement (Please tick)

I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, that is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	

I agree that by completing this form I have read and understood 'Things to Consider' above:

SIGNED			
PRINT NAME		**DATE**	

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Summary Care Records
My Choice

Forename(s) ……

Surname: ……

Date of Birth: ……

Signature: …… Date: ……..

	Tick (only ONE) as Applicable
1. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions or sensitivities to medications. This summary record will be held on an NHS Central Database and may be used in an emergency when your GP surgery is closed.	
2.* Yes I would like a Summary Care Record with medication, allergies and adverse reactions *PLUS additional important information held on my GP record (e.g. Diagnoses – Asthma (lung disease), kidney disease, renal disease, diabetes, epilepsy, cancer etc. and end of life care requests) AND/OR I will come and see my GP to discuss any additional information I would like added to my Summary Care Record as soon as possible.	
3. No I do not want a Summary Care Record Please be aware that if you choose not to have a Summary Care Record healthcare staff may not have access to important information about you in an emergency but be assured that you will be cared for to the best of their ability.	

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If you are enrolling on behalf of someone else, please provide the following information:

SIGNED			
PRINT NAME		**DATE**	
Do you have authority to access their medical record?	**Yes / No**		
Relationship to Patient			

FOR PRACTICE USE ONLY

Identity Verified (Tick all that apply) *Vouching* ☐ *Vouching with info in record* ☐ *Photo ID* ☐	*Name of Verifier*	*Date*
Name of person authorised to create account		*Date*
Date Account Creation		
Date of Passphrase Sent		