

This GMS1 form is for patients who have not been previously registered, permanently with an NHS GP. Please complete mandatory fields marked with X

If you would like to consent to Organ or Blood donor registration, please sign Page 2.

NHS Family doctor services registration		GMS1
Patient's details <i>Please complete in BLOCK CAPITALS and tick <input checked="" type="checkbox"/> as appropriate</i>		
<input checked="" type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname <input checked="" type="checkbox"/>	
Date of birth <input checked="" type="checkbox"/>	First names <input checked="" type="checkbox"/>	
NHS No. <input checked="" type="checkbox"/>	Previous surname/s <input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Town and country of birth <input checked="" type="checkbox"/>	
Home address <input checked="" type="checkbox"/>		
Postcode <input checked="" type="checkbox"/> Telephone number <input checked="" type="checkbox"/>		
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 <input checked="" type="checkbox"/>
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		
<input type="checkbox"/> 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>*Not all doctors are authorised to dispense medicines</i>
<input type="checkbox"/> I live more than 1 mile in a straight line from the nearest chemist		
<input type="checkbox"/> I would have serious difficulty in getting them from a chemist		
<input checked="" type="checkbox"/> Signature of Patient	<input type="checkbox"/> Signature on behalf of patient	Date <input checked="" type="checkbox"/>
Version 01/02		<i>Please see overleaf re: Organ donation</i>



Family doctor services registration

GMS1

NHS Organ Donor registration

I would like to join the NHS Organ Donor 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

Signature confirming consent to organ donation

Date

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

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