**FAMILY DOCTOR SERVICES REGISTRATION GMS1**

Completed the form below then either email or post it to the Practice.

Please complete in block capitals and **\*delete as appropriate**

|  |  |
| --- | --- |
| **Mr/Mrs/Miss/Ms \*** | Surname: |
| **Male/Female \*** | First Names: |
| Date of Birth | Previous surnames: |
| NHS No: | Town and country of birth: |
| Current address (including postcode):  Telephone No: Mobile phone No:  Email address: | |
| **Please help us to trace your previous medical records by providing the following information:**  Your previous address in UK:  Name and address of your previous doctor whilst at the above address: | |
| **If you are from abroad:**  Your first UK address where registered with a GP  If previously resident in UK Date you first came  Your date of leaving to live in the 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 years**  **YES/NO\*** I wish the child above to be registered for Child Health Surveillance | |
| **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 indicate organs/tissue you would like to donate:-    KIDNEYS/HEART/LIVER/CORNEAS/LUNGS/PANCREAS/ANY PART OF MY BODY**\* *Delete accordingly***  I, ***(insert name)*** confirm 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*](http://www.uktransplant.org.uk)*, or call 0845 60 60 400* | |

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**Please complete in block capitals and \*delete as appropriate**

|  |  |
| --- | --- |
| **Surname:** | **First Names:** |
| **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.  Have you given blood in the last 3 years **YES/NO\*** If yes please give date:  I, ***(insert name)***  confirm my agreement to be included 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 overleaf):-  **Date of Completion of Form by patient:**  **PLEASE EMAIL THIS FORM TO:** **thehighfieldmedicalcentre@nhs.net**  **Alternatively, you may print out and send it to us at the address below** | |
| **Part 2: To be completed by the doctor**  **Doctor’s 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 HS CHS list and will provide Child Health Surveillance to this patient\* * I have accepted this patient on behalf of the doctor named below, who is a member of this Practice and is on the HS CHS list and will provide Child Health Surveillance to this patient   **Doctors name, *if different from above***  *HA Code* | |
| 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 offices and auditors appointed by the Audit Commission.  Date  Authorised General Practitioner Signature (GP) | |