NHS Family doctor services registration

GMS1 downloaded from UWHC Website (12/2006)

If completing by hand please use BLOCK CAPITALS and tick boxes ✔ as appropriate.

Patients Details

○ Mr ○ Mrs ○ Miss ○ Miss

Date of Birth (DD/MM/YYYY)

NHS no.

○ Male ○ Female

Address (residence whilst at this University)

Postcode:

Surname/Family Name

First Names

Town and Country of birth

Telephone:

Mobile:

Email:

Please help us to trace your previous medical records by providing the following information:-

Your previous address in UK

Postcode:

Name of your 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 the UK, date of leaving

Date you first came to the UK:

If you are returning from the Armed Forces

Address before enlisting

Service/Personnel No.:

Enlistment date:

If you are registering a child under 5

☐ I wish the child to be registered with the doctor named overleaf for Child Health Surveillance

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 of behalf of patient	Date

Please complete, PRINT and sign and send to The Health Centre, University of Warwick, Coventry CV4 7AL

Please see overleaf for ORGAN DONATION

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 only
❑ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice:-

Doctor's 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

Doctor's name (if different from above) | HA code

❑ I will dispense medicines/appliances to this patient subject to the 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 authorsied officers and auditors appointed by the Audit Commission.

Authorised signature	Practice Stamp
Name / Date	

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

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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	***Print your name***	***Date***

If you would like to join the NHS Organ Donor Register, please complete this form, PRINT and sign it and send it to
The Health Centre, University of Warwick, Coventry CV4 7AL

For more information, ask for the leaflet on joining the NHS Organ Donor Register or visit the website at

http://www.uktransplant.org.uk