Registration process for NHS GP services

Please complete two forms – the GSM1 form and the Patient Registration Questionnaire. Both are found on this document.

The GSM1 form is to enable you to register for NHS services with our practice. You need to ensure you enter your University address and NOT your parent’s home address. Your NHS GP records will then be forwarded to our practice and will enable us to update your computer records.

The Patient Registration Questionnaire needs to be completed and is for our use only. This gives us an idea of your personal medical history. This information will be entered into your patient records at the surgery.

Please enter your University address and NOT your parents address in this area of the form.

For example:

Flat D22H, Thrumpton Halls, University of Nottingham
Sutton Bonington Campus, College Road,
Sutton Bonington, Loughborough. LE12 5RD
**Patient's details**

Please complete in BLOCK CAPITALS and tick ✓ as appropriate.

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr</td>
<td>Mrs</td>
</tr>
</tbody>
</table>

**Surname**

**Date of Birth**

**NHS No.**

**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:

<table>
<thead>
<tr>
<th>Your previous address in UK</th>
<th>Name of previous doctor at that address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address of previous doctor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are from abroad</th>
<th>Your first UK address where registered with a GP</th>
</tr>
</thead>
</table>

If previously resident in UK, date you first came to live in UK :

<table>
<thead>
<tr>
<th>If you are returning from the Armed Forces</th>
<th>Address before enlisting</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service or Personnel number</th>
<th>Enlistment date</th>
</tr>
</thead>
</table>

If you are registering a child under 5

| 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 live more than 1 mile 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

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**NHS Organ Donation registration**

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

Signature confirming consent to organ donation

Date

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

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**NHS Blood Donor registration**

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

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)

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**To be completed by your doctor**

<table>
<thead>
<tr>
<th>Doctors Name</th>
<th>HA Code</th>
</tr>
</thead>
</table>

- 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

<table>
<thead>
<tr>
<th>Doctors Name, if different from above</th>
<th>HA Code</th>
</tr>
</thead>
</table>

- I am on the HA 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 HA CHS list and will provide Child Health Surveillance to this patient.

<table>
<thead>
<tr>
<th>Doctors Name, if different from above</th>
<th>HA Code</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Authorise Signature</th>
</tr>
</thead>
</table>

Name

Date

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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

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HA use only Patient registered for

GMS  CHS  Dispensing  Rural Practice

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Please see right re: Organ donation
Name: ………………………………………………………. Date of Birth: …………………………………………..
Course Title: …………………………………………… Length of Course: ……………………. years
Telephone Number: ………………………………… University E Mail Address: ………………………………..
Country of Origin if newly arrived in UK: …………………………….. Date of Entry to UK: ………………………………..
(We require a copy of your passport before Registration)
1st Language Spoken: ……………………………………………
Ethnicity: Please select ONE of the choices below:
White Mixed Asian or Asian British Black or Black British
British White & Black Carribean Indian Carribean Chinese
Irish White & Black African Pakistani African Other Ethnic Background
Other White Background Other Mixed Background Bangladeshi Other Black Background
Other Asian Background
HEIGHT: ………………………………………………… WEIGHT: ……………………………
Have you ever smoked? YES/NO if YES Do you still smoke? YES/NO if YES Number per day …………..
Do you drink Alcohol? YES/NO if YES How many units per week? …………..
(1 Unit=1 measure spirit/1 small glass wine/½ pint beer)
Personal Medical History
Have you currently any of the following?
High Blood Pressure YES NO Date of Onset Last BP and Date 
Heart Disease 
Diabetes 
Asthma 
Epilepsy 
Thyroid Problems
Have you ever had any of the following?
Cancer YES NO Date of Onset What Type?
Stroke
Migraine
Mental Health Problems
Are you a Carer?
Are you allergic to any Medicines? YES/NO
If YES please specify

Please Turn Over to complete information on reverse
PLEASE COMPLETE IMMUNISATION RECORD (give approximate date when last vaccinated)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td>BCG or Mantoux Test (for TB)</td>
</tr>
<tr>
<td>Diptheria</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Polio</td>
<td>Typhoid</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>Pneumococcal</td>
</tr>
<tr>
<td>1st</td>
<td>2nd</td>
</tr>
<tr>
<td>Meningitis C</td>
<td>Other</td>
</tr>
</tbody>
</table>

Are you currently taking any prescribed medication?   YES/NO
If YES, please specify name and dose used (including inhalers and oral contraceptive pill)

NB: You will need to make an appointment with a Doctor to authorise repeat medications

Please give details of any surgical operations (with dates) or serious medical problems (with dates):

Do you have a learning disability or any other disability you would like us to know about?

Family History

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>State of Health or cause and age at death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has anyone in your family had: if YES, which member of the family
High Blood Pressure YES/NO
Diabetes YES/NO

Has anyone in your immediate family suffered a heart attack before age 60?

Has anyone in your immediate family suffered a stroke before age 60?

Thank you for completing this form.

Signature: .................................................. Date: ............................................

Finally: If you have completed any of the boxes in Personal Medical History, Family History, or have any questions that you would like to discuss with our Practice Nurse, please see the notice board to arrange an appointment. If you are unable to make one of the clinics on the notice board, please contact the Surgery for an appointment at a different time with the Practice Nurse.