The Rushey Green
Group Practice
The Primary Care Centre, Hawstead Road, London SE6 4JH
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DR JUDY CHEN MRS GILL SULTAN DR ALBERTO FEBLES



# 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 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

## 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

☐ 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*

**Not all doctors are authorised to dispense medicines*

☐ 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_____/_____/_____

Version 01/02

*Please see overleaf re: Organ donation*

# NHS Family doctor services registration

GMS1

**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 ☐ Any part of my body

*Signature confirming 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, or call 0300 123 23 23.*

**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

# CHILDREN REGISTRATION FORM – (under 16 years old)

**To register a child, we require evidence of the identity of those registering the child and their relationship to the child. We also require child's birth certificate and for children under 5 years old we need a copy of red immunisation book.**

**Please return fully completed forms to the Practice *in person*. Monday – Friday between 8.30am – 6.30pm .Please note during busy times you may have to wait, as the telephone's take priority.**

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**Patient Details:**

**Surname:**…… **First Name:**……

**Gender:** Male / Female **Age:** …… **Place of Birth:** ……

**Have you lived in UK for more than 5 years: Yes** ☐ **No** ☐

**If the answer to the above question is No, which year did you enter the UK?** …….

**If you have not lived in the UK for more than 5 years, which county/countries did you live in before coming to the UK?** ……

**Have you travelled abroad in the last 6 months? Yes** ☐ **No** ☐

**If the answer to the above question is Yes, which county/countries did you visit?**

……

**Home Address including Post Code:** ……

……

**Mobile Number:** …… **Home Number:** ……

**Email Address:**……

**School (if applicable**)……..

**Main language spoken:**…… **Interpreter needed:** ☐ **Yes** ☐ **No**

**Text Message Appointment Reminders**:

Do you want to use the SMS text message service? ☐ Yes ☐ No

**Ethnic Monitoring**

Please tick which ethnic group best describes your background?

| White | Asian or Asian British | Mixed | Black |
|---|---|---|---|
| ☐ British | ☐ Indian | ☐ Black Caribbean & White | ☐ Caribbean |
| ☐ Irish | ☐ Pakistani | ☐ Black African & White | ☐ African |
| ☐ Other White | ☐ Other Asian | ☐ Other Mixed | ☐ Other Black |

**Aged 16 – Smoking Information:**

( ) I have never smoked
( ) I currently smoke …… cigarettes

**I currently smoke and would like to give up smoking Yes/No**

**Parent/Guardian Contact Details:**

This helps to make sure the right people appear in the correct household on our computer system.

Mother's Details

Surname:…… First Name:……Date of Birth…….....

Address:……

Email:…….…….....Contact number……..

Father's Details

Surname:…… First Name: ……Date of Birth……..

Address:……..

Email:…….…….....Contact number……..

Guardian's Name: ……Relationship: .....

Telephone Number(s): ……

## Other Children in household:

| Name | DOB | Registered Here? Yes or No | Where registered if not at RGGP |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Other adult family members in same household:

| Name | DOB | Relationship to child | Registration here? Yes or no |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Parent to sign on behalf of child to confirm receipt of Rushey Green Group Practice Patient Agreement.**

**Signed…….**

**Date……..**

**For Office Use only**

| | |
|---|---|
| **Date Accepted:** | |
| **Name of Receptionist who checked form:** | |
| **Missing/Vulnerable Families Register checked (admin)** | |
| **Child's Red immunisation book and birth certificate attached to application:** | |
| **Safeguarding Lead/Social Services Involvement?** | |
| **Named Accountable GP, patient informed:** | Dr Chen or Dr Febles |
| **Details entered on EMIS:** | |
| **Photocopy of GMS1 if under 5 years for Health Visitors:** | Yes or No |

# Rushey Green Group Practice Patient Agreement

**Please understand that by completing and signing this form you agree to the following:**

a) That you have completed the registration questionnaire to the best of your knowledge.
b) To keep your appointments and if you are unable to do so you will inform the practice as soon as possible. (We will remind you of your appointments by text if you give us a mobile number).
c) To keep us updated of any change of address or telephone number
d) To behave towards the Practice staff as you would expect us to behave towards you, not using threatening, aggressive or bullying behaviour towards our staff / other patients.
e) To not deface or cause damage to any part of the building or its grounds.

**Signature on behalf of Patient:**..... **Date:** ..... / ..... / .....

**Name:……..Relationship:……**

## What Happens Next?

- Please take these completed forms to the Practice anytime Monday – Friday between 8.30am – 6.30pm together with your child birth certificate and red childhood immunisation book, and you can expect to be registered within 5 working days.
- You will be given a New Patient Pack upon registering which contains all the information about the practice that you will need.
- If we are unable to register you, we will notify you of the reasons in writing.
- Your NHS medical card will be sent to you from NHS England within 12 weeks of registration if you are new to the area.
- Your named GP will be Dr……..……... but you are entitled to see any Doctor at the Practice.
- You are encouraged to ask to see the same Doctor whenever you book a routine appointment. For an urgent appointment you will be allocated any of the doctors available for the session.

**THANK YOU FOR COMPLETING THIS FORM.**