

WHS Family doctor services registration GMS1 THE ELMS



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	is a second of the second of t
Postcode	Telephone number
Please help us trace your previ	ous medical records by providing the following information 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 A Address before enlisting	rmed Forces
Service or Personnel number	Enlistment date
If you are registering a child ur	nder 5
☐ I wish the child above to be reg	stered with the doctor named overleaf for Child Health Surveillance
If you need your doctor to disp	ense medicines and appliances* *Not all doctors are
☐ I live more than 1 mile in a strai☐ I would have serious difficulty in	disperise medicines
Signature of Patient Signa	ature on behalf of patient Date/



Family doctor services registration

GMS1

I want to registe after my death.	Please tick the l	the NHS Orgar boxes that ap		s someone who	se organs/tissue may l	be used for transplantation
	organs and tiss					7
Kidneys	Heart	Liver	Corneas	Lungs	Pancreas L	Any part of my body
Signature conf	firming my agre	eement to or	gan/tissue dona	tion	Date	/
For more i www.uktra	nformation, ple ansplant.org.uk	ease ask at re s, or call 0300	ception for an i	nformation lea	flet or visit the web	site
I would like to jo Tick here if you	ı have given bl	od Donor Regi ood in the la	Production of the last of the			prepared to donate blood.
		ation is: (only	if different froi	n above, e.g. y	d Donor Register our place of work)	
					r ostcode	
To be compl	eted by the	doctor				
Doctors Name					HA Code	
☐ I have accep	ted this patient f	or general me	dical services			
	vision of contrace					
			dical services on be	half of the doct	or named below who	is a member of this practice
		3				
Doctors Name	f different from	a about		* * *		
Doctors Name, i	f different fron	n above			HA Code	
Doctors Name, i	f different fron	n above				
☐ I am-on the	e HA CHS list ar	nd will provid	le Child Health S		HA Code this patient or	
☐ I am on the	e HA CHS list ar	nd will provid		ned below, wh	HA Code this patient or	nis practice and is on the
☐ I am on the	e HA CHS list ar oted this patien and will provid	nd will provid t on behalf c le Child Healt	of the doctor na	ned below, wh	HA Code this patient or	nis practice and is on the
I am on the	e HA CHS list ar oted this patien and will provid	nd will provid t on behalf c le Child Healt	of the doctor na	ned below, wh	HA Code this patient or to is a member of th	nis practice and is on the
☐ I am on the☐ I have accep HA CHS list Doctors Name, i	e HA CHS list ar oted this patien and will provid f different from	nd will provid it on behalf c le Child Healt n above	of the doctor na ch Surveillance to	ned below, who this patient.	HA Code this patient or to is a member of th	
I am on the I have accepted HA CHS list Doctors Name, i	e HA CHS list are oted this patien and will provid f different from ase medicines/ap	nd will provided to n behalf of the child Health of the child Heal	of the doctor name in Surveillance to	ned below, who this patient.	HA Code this patient or to is a member of the HA Code uthority's Approval	
☐ I am on the ☐ I have accept HA CHS list Doctors Name, i ☐ I will dispen ☐ I am claiming Distance in I declare to the Statement of F	e HA CHS list are beed this patien and will provide fifterent from a see medicines/aparticles between the best of my believes and Allowalditors appointed	nd will provident on behalf of the Child Health above opliances to the payment formy patient's lief this information. An auditional contents of the contents o	the doctor name of the Surveillance to the Sur	ned below, who this patient. ect to Health A and my main su	HA Code this patient or to is a member of the HA Code uthority's Approval	
I am on the HA CHS list Doctors Name, i	e HA CHS list are beed this patien and will provide fifterent from a see medicines/aparticles between the best of my believes and Allowalditors appointed	nd will provident on behalf of the Child Health above opliances to the payment formy patient's lief this information. An auditional contents of the contents o	the doctor natch Surveillance to the Surveillance to this patient subject this patient. The home address a mation is corrective trail is availabilit Commission.	ned below, who this patient. ect to Health A and my main su	HA Code this patient or to is a member of the HA Code	nent as set out in the
☐ I am on the ☐ I have accept HA CHS list Doctors Name, i ☐ I will dispen ☐ I am claiming ☐ Distance in I declare to the Statement of Fofficers and au	e HA CHS list are beed this patien and will provide fifterent from a see medicines/aparticles between the best of my believes and Allowalditors appointed	nd will provident on behalf of the Child Health above opliances to the payment formy patient's lief this information. An auditional contents of the contents o	the doctor name of the Surveillance to the Sur	ned below, who this patient. ect to Health A and my main su	HA Code this patient or to is a member of the HA Code	nent as set out in the