

## Patient's details

Please complete in **BLOCK CAPITALS** and tick  as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> 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

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If previously resident in UK, date of leaving	Date you first came to live in UK
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## If you are returning from the Armed Forces

Address before enlisting

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Service or Personnel number	Enlistment date
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## 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

### 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*

*Date*

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

### 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 CHSlist 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

**SUMMARY OF TREATMENT CARD**

Surname: \_\_\_\_\_ Forename(s): \_\_\_\_\_

Address: \_\_\_\_\_

N.H.S. Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DATE \_\_\_\_\_ CLINICAL NOTES

Tel. No: \_\_\_\_\_

Single/Married/Re-married/Divorced/Separated/Widowed \_\_\_\_\_ (Please Circle)

Own Occupation: \_\_\_\_\_

Husband/Wife Occupation: \_\_\_\_\_

Family History	Age if Alive	Any Serious Illness	Age at Death	Cause of Death
Father: .....				
Mother: .....				
Brothers & Sisters .....				
Children .....				

Year \_\_\_\_\_ Past Serious Illnesses, operations or accidents .....

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Any Present Illness .....

Allergies - drugs .....

Other allergies .....

Tablets being taken at present (including contraceptive pill if applicable) .....

Name and address .....

of last Doctor .....

Signature .....

**REGISTRATION CONSULTATION OFFERED**

Date	Exercise	Height	Weight	Urine	BP	Cholesterol
Last Tetanus Injection						
Last Cervical Smear						
Smoking Habits						
Alcohol Intake						
Diet						

Advice .....

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