**4EEEE**

***For Office Use only: Does this patient need a New Patient Check? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***REGISTERED BY…………………………***

*ID SEEN – Please state ID type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PST initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*PST’s please clearly write*

*Forenames-­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_…………………………………………..*

**BRIMINGTON SURGERY - NEW PATIENT REGISTRATION FORM**

Please fill in this questionnaire to enable us to assess any treatment you may need in the near future. Any other medical history will be transferred from your medical records when we receive them from your previous GP.

**DEMOGRAPHICS:** **NHS Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth ­­­**\_\_\_\_\_\_\_\_\_\_\_\_

**Title**: Mr Mrs Miss Ms Mx Dr Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which of the following best describes you?**

Female (including Trans Woman) Male (including Trans Man) Non-binary

**Is your gender identity the same as the gender you were given at birth?** Yes/No

**First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Surname**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Surname/s**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Town & County of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P**ostcode**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Landline** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mobile phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your Preferred Method of Contact:** Phone call/ Text Message/ Email/ Letter

**Can we contact you via SMS** YES/NO **Can we contact you via email** YES/NO

**Which of the following options best describes you?** Heterosexual/Straight Lesbian/Gay Bisexual

**What is your Ethnic Origin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What is your first language**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |
| --- | --- |
| **Your previous address in the UK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **Name and address of previous GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
|  |  |
| |  | | --- | | **If you are from overseas:**  **Your first UK address where registered with a GP**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date you first came to live in UK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If previous resident of UK, Date of leaving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |  |
|  |  |
| *Patients who are not ordinarily resident in the UK (which broadly means living lawfully here on a properly settled basis for the time being) may have to pay for NHS treatment outside of the GP surgery.*  ***Please ask for the additional declaration form if you are not ordinarily resident in the UK***   |  | | --- | |  | |  | |  | | Discharge Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
|  |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are returning from the armed forces:**

**The last base you lived at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle as appropriate: ARMY** *(For office use XaP9d***) NAVY** *(XaP9f***) RAF** ***(****XaP9g)*

Service or personnel number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enlistment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PERSONAL MEDICAL HISTORY:

**Height** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a history of any of the following?**

Asthma Yes/No Anti-coagulation (INR) Yes/No

Cancer Yes/No Cardiovascular Disease Yes/No

COPD Yes/No Diabetes Yes /No

Epilepsy Yes/No High Blood Pressure Yes/No

Hypertension Yes/No Mental Health Problems Yes/ No

Rheumatology Yes/No Stroke/TIA Yes/No

Substance Misuse Yes/No

**Any other illnesses you think we might need to know**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any operations you have had\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies / please list \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACCESSIBLE INFORMATION STANDARDS :**

**Do you have any disabilities?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any communication or information needs?** Yes/No

**Please let us know what these are so we can do our best to support you: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS AND VACCINATIONS:**

**Please list any medicines or tablets you are taking on a regular basis.** *Attach a repeat prescription list if possible*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which pharmacy would you like to nominate to receive electronic prescriptions where appropriate?**

**Name of pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Tetanus**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Polio**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other immunisations**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES ONLY:**

**Please inform us if you take Sodium Valproate and are of child bearing age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently pregnant** YES/ NO **Which method of contraception do you use** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate date of your last smear**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate date of your last breast screening**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING:**

**Do you smoke?** YES/NO **OR** Used to but gave up in/on *(please give date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Yes**: Cigar/Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you considered giving up** YES/NO **Would you like some stop smoking advice?** YES/NO

**ALCOHOL:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **QUESTIONS** | 0 | 1 | **SCORING SYSTEM**  2 | 3 | 4 | **YOUR**  **SCORE** |
| How often do you have a drink that  contains alcohol? | Never | Monthly  or less | 2 - 4 times  per month | 2 - 3 times  per week | 4+ times  per week |  |
| How many standard alcoholic drinks  do you have on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often do you have 6 or more  standard drinks on one occasion? | Never | Less than  monthly | Monthly | Weekly | Daily or  almost daily |  |

**Scoring:** *Government Guidelines suggest that a total of 5+ indicates hazardous or harmful drinking. Should you score 5 or more, you may get a follow up letter from the surgery.*

**PHYSICAL ACTIVITY:**

**Do you exercise** YES/NO **How many times a week**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long for**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **What types of activity?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARERS**:

Do you look after any of the following (who need support due to a physical or learning disability/illness?)

Relative Child Friend

*If yes and you would like more information please ask for our Carer’s leaflet – you may be entitled to free annual influenza vaccinations*

*If yes and you would like more information please ask for our Carer’s leaflet – you may be entitled to free annual influenza vaccinations*

**NEXT of KIN** *(if you wish this information to be entered on your record)*

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to you**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

Have your parents or siblings had any of the following when they were **under 65 years of age**

(if yes, please give brief details):

**YES NO (*For Office Use*)**

Stroke 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ZM1Jg)

Heart attack 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (XE0oF)

Hypertension 🞏 🞏 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (12C1)

Diabetes Mellitus 🞏 🞏 ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1252)

**NHS ORGAN DONOR REGISTER:**

From 20 May 2020, organ donation in England will move to an 'opt out' system.

This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the following excluded groups:

* Those [under the age of 18](https://www.organdonation.nhs.uk/uk-laws/under-18/)
* People who lack the mental capacity to understand the new arrangements and take the necessary action
* Visitors to England, and those not living here voluntarily
* People who have lived in England for less than 12 months before their death

If you still wish to record your preferences, you can still do so directly through the blood and organ donation online registration websites, or by phone:

1. Blood donation: [https://www.blood.co.uk](https://lnks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDcsInVyaSI6ImJwMjpjbGljayIsImJ1bGxldGluX2lkIjoiMjAyMTA5MDIuNDUzODAzMzEiLCJ1cmwiOiJodHRwczovL3d3dy5ibG9vZC5jby51ay8ifQ.uDJzVjxIWGcJvxyctb_hUE7uK0muV2TOQNYe9uuM2_w/s/1186093430/br/111775792099-l)
2. Organ donation: [https://www.organdonation.nhs.uk](https://lnks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDgsInVyaSI6ImJwMjpjbGljayIsImJ1bGxldGluX2lkIjoiMjAyMTA5MDIuNDUzODAzMzEiLCJ1cmwiOiJodHRwczovL3d3dy5vcmdhbmRvbmF0aW9uLm5ocy51ayJ9.adsGEV7eaIYAg4aHYr_gJYPzd_IM0j-L4ErgESQfP_Q/s/1186093430/br/111775792099-l)
3. Blood or organ donation by phone: 0300 123 23 23

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If you require online access to book appointments, order medication or***

***view your records please continue to the next section***

**DATA SHARING:**

Unless you tell us otherwise, other professional providers of care will be able to view limited parts of your medical records BUT unless you are unable to respond at the time of treatment, consent will ALWAYS be asked. Having this information stored in one place makes it easier for healthcare staff to treat you outside of your GP practice.

**Summary Care Record (SCR)**

A Summary Care Record is an automatically created real time electronic record which includes medication including adverse reactions and allergies.

**Summary Care Record – SCR Additional Information**

This is an additional enhancement to the SCR service described above. You will need to explicitly request this. The additional information will include the following: Significant problems (past and present); significant procedures (past and present); Anticipatory care information and communication preferences; End of life care information; Immunisations

*Sensitive items related to IVF, STDs, terminations, gender re-assignment etc are automatically excluded so if you require these to be included you need to provide specific consent for these to be added*

You can change your mind at any time about whether or not you have a Summary Care Record, but you will need to tell us.

I have decided to opt in to: Standard SCR plus Enhanced SCR

I have decided to opt out of SCR 

**Sharing methods outside of GP service**

This is via the Medical Interoperability Gateway (MIG) - a different method of sharing information held on your records and is ONLY shared with appropriate professional services who have undergone security assessments (eg Ambulance and Out of Hours Services, Community Health; Social Care) and are working with you to provide support, so your information is available when it is needed most.

Health and Social Care Professionals will still ask for your consent to view certain information when treating and supporting you, which means that you are always presented with an option to agree or disagree.

The only exception is ‘duty of care’, which means that confidentiality can be over-ridden, if, for instance, there are safeguarding concerns about someone’s welfare or in a medical emergency and consent cannot be obtained. Only authorised health and social care staff involved in your care would be able to access your information, and only specifically to be able to do their job.

Access to SCR and MIG is in a coded format across secure NHS networks and accessed by trained Health Professionals with Chip and Pin smartcard access with relevant access rights embedded in it.

**Are you happy for:**

Information on our computer systems to be seen by Clinicians treating you in other health care settings

YES/NO

This practice to view the information recorded about you at other healthcare settings YES/NO

**PATIENT ONLINE ACCESS TO RECORDS (POLAR); APPOINTMENTS**

**& REPEAT MEDICATION**

We offer online appointment booking, prescription ordering and access to your summary or detailed coded, medical records. Examples of the coded information you will be able to view includes: vaccination history, coded consultations, and test results.

Your medical record will be reviewed by a clinician prior to online access being granted. Application does not necessarily mean access will automatically be granted.

If approved, we will provide you with a username and password which will allow you to access the online clinical portal (SystmOnline). If for any reason we do not grant access to your medical records, you will be contacted to discuss the reasons for this decision.

**Important Information – Please read before returning this form**

**It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**

If you can’t do this for some reason, we recommend that you contact us so that we can remove online access until you are able to reset your password.

**If you print out any information from your record, it is your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details:

|  |
| --- |
| **Forgotten history -** There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news -** If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone -** It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion -** If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information -** Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| **Information about someone else -** If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

If you find anything difficult to understand, as well as talking to us, you can go to the NHS Choices website by using this link [www.nhs.uk](http://www.nhs.uk) . This is the NHS website for patients so you can look for information on illnesses, improving health and to find NHS services in your local area.

Other websites used to search for information on illnesses and test results are www.patient.info

and www.labtestsonline.org.uk. Although these are not owned or checked by the NHS, other patients have found them useful.

***Please complete form A for Access for yourself or Form B for Proxy Access if required***

We require, two forms of documentation as evidence of identity, one must contain a photograph. Acceptable documents include passports, photo driving licences and bank statements. If none of the above is available household bills may be accepted at the discretion of the Practice Manager.

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | | |
| First name |  | | |
| Date of birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | | |
| Telephone number |  | Mobile number |  |

## I wish to have access to the following online services (tick all that apply):

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Accessing my medical record | 🞏 |

# Application for online access to my medical record:

I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * I have read and understood the information accompanying this form | | | | 🞏 |
| * I will be responsible for the security of the information that I see or download | | | | 🞏 |
| * If I choose to share my information with anyone else, this is at my own risk | | | | 🞏 |
| * I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | | | 🞏 |
| * If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | | | | 🞏 |
| * If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. | | | |  |
| Signature |  | Date |  | |

**For practice use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Identity verified by | Date | | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  Declined   Detailed coded record   Parts Redacted  | | Notes / explanation | | |

**FORM A**

**CONSENT TO PROXY ACCESS TO GP ONLINE SERVICES:**

**Proxy** - a person authorised to act on behalf of another or the authority to represent someone else.

If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient’s best interest section 1 of this form may be omitted. Proxy access application will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

We require, two forms of documentation as evidence of identity for each party involved (including the patient - this might be waved when the proxy is clearly the parent/person with Parental Responsibility), one must contain a photograph. Acceptable documents include passports, photo driving licences and bank statements. If none of the above is available household bills may be accepted at the discretion of the Practice Manager.

***Note****: Up until a child’s 13th birthday, the usual position would be for the parents of the child to control access to their child’s record and online services, this will cease automatically when the child reaches the age of 13. Any subsequent proxy access will need authorisation by the patient subject to a (Gillick) competency test being completed by a clinician.*

**Section 1 - The patient** *(This is the person whose records are being accessed)*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I,……………………………………………….., give permission to my GP practice to give the following

people :…………………………………………… …..…………….. proxy access to the online services

as indicated below in section 2.

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand the risks of allowing someone else to have access to my health records.

I have read and understand the information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Accessing Medical Record | 🞏 |

**FORM B**

**Section 3**

I/we…………………………………………………………………………….. (Names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……………………………………….(Name of patient).

I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement | 🞏 |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | 🞏 |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date/s |

**The REPRESENTATIVES**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription.)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| Address  Postcode | Address *(tick if both same address 🞏)*  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Identity verified by | Date | | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  Declined   Detailed coded record   Parts Redacted  | | Notes / explanation | | |