REGISTRATION PACK FOR SOUTHCOTE CLINIC

Please attend reception with your completed forms during normal surgery hours. During busier times we will not be able to check forms. Please ensure that you follow the instructions carefully and include all relevant documents

For surgery use only

REG	
SCANNED	
GP2GP	
NOK	
GP	
SCR	
CODES	
GMS1	
CHEMIST	
NURSE	
DONOR	
H/V	
INFORM	
INPUT	

PATIENT REGISTRATION CHECK LIST	TICK
GMS1 FORM www.nhs.uk/Servicedirectories/Documents/GMS1.pdf	
REGISTRATION QUESTIONNAIRE	
OPT IN/OPT OUT SUMMARY CARE FORM	
PROOF OF ID BIRTH CERTIFICATE, VALID PASSORT OR DRIVING LICENCE (PHOTO)	
PROOF OF ADDRESS Utility Bill (within the last 3 months) A Driving licence is not acceptable as proof of address	
CHILD HEALTH RECORD If you are registering a child under the age of 5 years please bring his or her Child Health Record (RED book) We also need a record of immunisations for children up to the age of 18	

PLEASE NOTE THAT INCOMPLETE FORMS WILL BE RETURNED WHICH WILL DELAY YOUR REGISTRATION

The surgery will advise you by telephone or text when you are registered

SOUTHCOTE CLINIC REGISTRATION QUESTIONNAIRE - CONFIDENTIAL To be completed prior to Registration	
DATE:	**BIRTH CERTIFICATE OR PASSPORT AND PROOF OF ADDRESS TO BE SEEN WHEN REGISTERING**
Surname:	**Forename(s):**
Address:	
Tel Number: Home: **Email:**	**Work:** **Mobile:** **SMS Consent: (appointment/Referral updates)** — **Yes** [ ] **No** [ ]
Date of Birth:	**Town & Country of Birth:** ***(eg: Paddington, England)***
Ethnic Origin: **(eg: British/Asian)**	**Next of Kin:** **Relationship:** **Telephone number:** **Use Next of Kin as emergency contact** — **Yes** [ ] **No** [ ]

Do you look after someone who is ill, frail, disabled or has a mental health problem? Yes No
If you circled yes please ask for a Carers Pack from Reception

Personal Medical History (Have you got or have you had any of the diseases listed below?)

	Yes	No	If Yes please give details
Diabetes			
Asthma/COPD. Any breathing problems for which you regularly use an inhaler			
Hypertension – High Blood Pressure			
Cancer			
Epilepsy			
Thyroid problems: Over or under active thyroid			
Mental Health Problems Including depression treated with medication			
Heart Disease			
Stroke / TIA			
Operations or Hospital In Patient treatment			

If you are registering a child under the age of 5 years please bring his or her Child Health Record (RED Book)

We also need a record of immunisations for children up to the age of 18

IT IS ESSENTIAL THAT ALL DETAILS BELOW ARE COMPLETED
ALL INCOMPLETE APPLICATIONS WILL BE RETURNED AND WILL DELAY YOUR REGISTRATION

Ladies only **Have you had a Cervical Smear?**	**Yes**		**Date:**
	No		**Place:**
			Result:
			Recall Date:

Please enter your Weight in kg **(Scales and height measure are available here)**		**Please enter your Height in cm:**	

Do you smoke?	**Yes**		**If Yes how many a day**	
	No		**and what? (Cigarettes/Cigars/Pipe)**	
If given up, when?			**How many a day did you smoke?**	

Would you like advice on giving up smoking?	**Yes**		**No**	

Drinking **Do you drink alcohol?**	**Yes**		**If Yes how many units a week?** ***1 unit=1/2 pt beer, a small glass of wine or a 25ml measure of spirit***	
	No			
Occupation				
Are you on any special diet?	**Yes**		**If Yes what?** ***Eg Low cholesterol, Low Salt, Diabetic***	
	No			

Family History **Did or does any of your family suffer from any of the problems listed below? Please indicate using the abbreviations underneath** **(M=Mother,F=Father,B=Brother,S=Sister,A=Aunt,U=Uncle,MGF=Maternal Grandfather,MGM=Maternal, Grandfather,PGM=Paternal Grandmother,PGF=Paternal Grandfather**		
Blindness / Glaucoma	**Abnormal Blood Pressure**	**Diabetes**
Asthma	**Cancer**	**Stroke**
Heart Attack	**Thyroid**	

Carers	**Please advise us if you are a carer. We can provide you with information on the help that is available**

Medication **Do you have regular medication?**	**Yes**		**If Yes.** **Please attach your Repeat Prescription Form from your current Doctor. This is for our records only and is not a request for medication. If this is your only copy, please ask us to photocopy it for you.** **You will be asked to make an appointment with the Doctor before your next prescription is due.**
	No		
Do you have any allergies? **Eg Hayfever**	**Yes**		**Please give details**
	No		

Immunisation and Vaccinations Have you had any vaccinations in the last 10 years?	**Please give details:**

Over 65s or Medically Advised (eg Diabetic, Steroid dependant Asthmatic)			
Do you have an annual Influenza Vac?	**Yes**		**If No, and you do not want one, please sign the attached Dissent Form**
	No		
Have you ever had an Influenza Vac?	**Yes**		
	No		

PLEASE COMPLETE THIS FORM IN FULL AS APPLICABLE

There may be some investigations or Services you do not wish to participate in.

It would help us to keep accurate data if you would let us know if this is the case for the following Services.

(You can, of course, change your mind at any time – just let us know)

CERVICAL SMEAR

I do not wish to have a cervical smear performed

	Please tick	*Details if applicable*
Personal reasons		
Medical Reasons		
Other		

Name: ………………………………….. Signature ……………………………………………
Date …………………………….

INFLUENZA VACCINATION
Over 65s or in an At Risk Category

	Please tick
I do wish to have an annual influenza vaccination	
I do not wish to have an annual influenza vaccination	

Name ………………………………………….. Signature ……………………………………………
Date …………………………

EMIS ACCESS

If you would like to register to enable on-line booking of Doctor's appointment or requests of repeat medication please go to: www.patient.co.uk and select the Patient Access tab

SOUTHCOTE CLINIC IS A TEACHING PRACTICE

From time to time we contact patients to see whether they could help us in a training session

NAMED ACCOUNTABLE GP FOR ALL PATIENTS

It is an NHS requirement that all patients are allocated a Named GP. However you will be able to book an appointment with any GP or Practice Nurse working at the clinic. If you have a preference to a particular GP the practice will make reasonable effort to accommodate your request

Your names GP will be:

DR ASOKA WIJAYAWICKRAMA (Male)

Summary Care Record
Your Medical Records – Your Decision

Summary Care Record

Summary Care Record (SCR) is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care**.** The Summary Care Record is meant to help emergency doctors and nurses help you when you contact them when the surgery is closed.

This means they can give you better care if you need health care away from your usual doctor's surgery:

- in an emergency
- when you're on holiday
- when your surgery is closed
- at out-patient clinics
- when you visit a pharmacy

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

At a minimum, the **Basic Summary Care Record** holds important information about;

- current medication
- allergies and details of any previous bad reactions to medicines
- the name, address, date of birth and NHS number of the patient

The patient can also choose to include additional information that could be important to your treatment, and this is called an **Enhanced Summary Care Record** and it includes:

- details of long-term conditions
- significant medical history
- specific communications needs and personal preferences
- Immunisations

It also provides full health information if you need to call an ambulance, contact 111 or out of hours service or go to hospital anywhere in England. It is quick, secure and safe for health and care staff to access your SCR.

What are my options?

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

1) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only

2) **Express consent for medication, allergies, adverse reactions and additional information.**

3) **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

Having read the above information regarding your choices, please choose **one** of the options below

Yes – I would like a Summary Care Record

□ Express consent for medication, allergies and adverse reactions only.
or
□ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record (opt out).

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice

Southcote Clinic

Application for online access to my medical record

<u>Please ensure you have read the information leaflet: What you need to know about your GP online records BEFORE completing this form.</u>

Surname		**First Name(s)**	
Address			
Email		**Date of Birth**	
Telephone		**Mobile Number**	

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

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

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

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	
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
If I see information in my record that is not about me or is inaccurate, I will 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**	

I understand that I may be contacted by the Practice to asses this service and I am happy to provide the above information to Southcote Clinic. **<u>Please submit this completed application form along with photo identification (ie photo driving licence or passport) to reception.</u>** Please collect your login details in person allowing 21 days to process.

<u>To be completed by reception staff</u>

Copy of identification taken: (please circle) Passport Photo Driving Licence Other

Staff Name ………………………………………………….. *Date ……………………………….*