NHS Family Doctor Services Registration

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 & country of birth:

Home address:

Postcode: Email:

Home telephone: ☐ Please tick if this is your preferred contact number

Mobile telephone: ☐ Please tick if this is your preferred contact number

Work telephone: ☐ Please tick if this is your preferred contact number

Occupation: Next of kin:

Do you have a carer? yes / no If yes, please give name: and date of birth:

Are you a carer? yes / no If yes, please give name: and date of birth:

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

Previous address in the 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 the UK, date of leaving: Date you first came to live in the UK:

If you are returning from the armed forces:

Address before enlisting:

Service or personnel number: Enlistment date:

Text reminder service:

We send out appointment and other reminders (for example, invites for annual reviews) by text message. If you do not have a mobile phone, we may send information out by an automated voice message to your land line.
This service is provided to patients over the age of 16 only.
You may opt out of the service by ticking this box ☐

Online Access

Our practice has the facility to book appointments with a doctor, order repeat medication & view aspects of your medical record online. We encourage our patients to use this facility as it is available 24 hours a day, 7 days a week and it is more efficient than ordering by phone or in person. Should you wish to use this service, please present one form of identification to the reception team and they will issue a registration form.

This facility is also available for parents to use on behalf of their children but only until they reach the age of 12 years old

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Electronic Prescribing

Any prescriptions issued by the practice are normally sent electronically to your nominated pharmacy. Please nominate your chosen pharmacy here:

NHS Summary Care Record (SCR):

The SCR is an electronic patient summary containing key clinical information that is accessible by authorised healthcare staff outside of your doctor's practice in an urgent or emergency situation. An SCR is optional and you can choose whether or not to have one. Furthermore where you have an SCR it should only be accessed with your permission except in exceptional circumstances, for example, emergency access if you are unconscious. The SCR contains information about your medications, allergies & adverse reactions and is taken directly from the medical record held by your GP. If you are happy to have a summary care record, no further action is required. Should you wish to opt out of having a summary care record, please tick this box: ☐

NHS Full Record Sharing:

Your full record with a GP is not routinely shared with other NHS healthcare providers. This means that when you use other NHS services (like community physiotherapy, districts nurses etc) or when you attend hospitals, the healthcare professionals are unable to see your medical record. Conversely, when you receive treatment outside of the GP surgery, we are unable to see details of your consultation other than when we are sent a letter detailing the summary of your treatment.

Many NHS computer systems now have the functionality to allow their records to be shared across NHS organisations and we believe that better sharing of information between providers will result in improved safety & efficiency of the healthcare system. However, this can only happen with your permission.

In order for your records to be shared, you need to grant access at both ends. Therefore, by granting permission at the practice alone, this will not result in any additional sharing of information. The sharing agreement is only finalised when you grant permission with another provider at the point of use.

We will therefore set your record to allow sharing in & out of this practice unless you advise us otherwise. If you do not want to allow record sharing, please tick this box: ☐

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 or tissue **or**

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation ..... Date .....

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 Donation Register ..... Date .....

My preferred address for donation is (only if different from above, e.g. your place of work):

..... Postcode: .....

Smoking Data:

Please provide details of your smoking history so we can add this to your medical record. Thank you.

Never smoked (✔) ☐

Ex smoker (✔) ☐
Year stopped ☐
Quantity per day ☐

Current smoker(✔) ☐
Quantity per day ☐

Alcohol Data:

Please provide details of your alcohol consumption in units per week so we can add this to your medical record. Thank you.

Average quantity in units per week: ☐

Ethnicity and main spoken language:

We are required to ask you to provide details of your ethnic origin for statistical purposes. Please tick one box below. Thank you.

- ☐ British or mixed British
- ☐ Irish
- ☐ Caribbean
- ☐ African
- ☐ Indian or British Indian
- ☐ Pakistani or British Pakistani
- ☐ Bangladeshi or British Bangladeshi
- ☐ Chinese
- ☐ White and Asian
- ☐ Other Asian background
- ☐ Other black background
- ☐ Other mixed background
- ☐ Other

We are required to ask you to provide details of your main spoken language for statistical purposes. Please tick one box below. Thank you.

☐ English ☐ Other (please specify)

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Signature:

☐ Signature of patient signed: Date:
☐ Signature on behalf of patient …… ……

PLEASE RETURN THIS FORM TO THE RECEPTIONIST TO COMPLETE THE REGISTRATION PROCESS.
IT WOULD BE HELPFUL IF YOU COULD BRING ONE FORM OF IDENTIFICATION.

To be completed by the administration team

Specify form of ID checked (e.g. passport): ……

Checked by: ……. Date: ……..

To be completed by the doctor

Doctor's name

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I declare that to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees & 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