CLAREMONT BANK SURGERY
New Patient Registration Form

TEL: 01743 248244

Thank you for applying to join the list of Claremont Bank Surgery.

PREVIOUSLY REGISTERED WITH US? YES / NO

TITLE

MR ☐ **MRS** ☐ **MS** ☐ **MISS** ☐ **DR** ☐ **OTHER** ☐

Surname: _____

First name: _____ **DATE OF BIRTH:** _____

Place of Birth: _____

If the patient is under 16 please provide details of other members in the household below:

Name	Relationship to patient	Contact number

IMMIGRANTS: - What date did you arrive in the United Kingdom? _____

Are you in THE ARMED SERVICES? YES/NO

Dates of Joining _____ **Date of Leaving** _____

NEW/CURRENT ADDRESS:

PREVIOUS ADDRESS:

CONTACT DETAILS:

(Please only give us contact numbers that you would be happy for us to contact you on- no personal information will be disclosed on a messaging service.)

Email:

Mobile:

Home: **Work:**

NAME OF PREVIOUS GP: GP ADDRESS:	**YOUR NAMED ACCOUNTABLE GP IS:** **DR ZIKO** **You can still see all the other Doctors in the surgery. If you would like to specifically nominate a GP please tell the receptionist.**

- If you would like a Registration Form to ORDER YOUR REPEAT PRESCRIPTIONS ONLINE and also to BOOK YOUR APPOINTMENTS ONLINE please ask at reception when you attend for your new patient check. ***ID will be required for those aged 18+***
- (Please note we do not take prescription requests over the telephone)
- Would you like to receive emails with our Monthly Newsletter? **YES / NO**
- A text message can be sent to you 24 hours in advance of any appointment you may have booked at the surgery. Would you like to receive this service? **YES / NO**

Emergency Contact Details:

Full name:

Contact number:

Relationship to patient:

- **Do you have a 'Living Will' (also known as an Advance Decision) explaining the medical treatment you want in the future?**

YES/NO

If YES, please bring a copy of this to your New Patient Health Check.

- **Have you nominated someone to speak on your behalf (Power of Attorney)?**

YES/NO

If YES, please provide their details in the space below.

Full name:

Contact number:

Relationship to patient:

- **If you are a carer please provide the contact information for the person you care for:**

Full name:

Address:

Postcode:

Contact number:

- **If <u>you have a carer</u> please provide the contact information for the person who cares for you:**

Full name:

Address:

Postcode:

Contact number:

- **Would you like more information on the kinds of support Becky, our Community Care Coordinator could offer you?** *A Community and Care Co-ordinator is based in your local GP practice. They assist patients in need of help, support and advice by signposting them to other useful services. Community and Care Co-ordinators work with the NHS, the Council and voluntary services and have become local experts on what's happening in your community. They can help you to keep socially active and maintain your independence.*

YES/NO

If YES, Becky will send you some more information about her role with the surgery and ways in which she could help.

Ethnic Origin

White - British		White - Other	
Black - African		Black - Caribbean	
Black – Other		Asian	
Mixed Race		Other	

First language spoken:

- **Do you require a translator?**

YES/NO

Accessible Information Standard

- **Would you like us to contact you in a certain way? (For example, large print documents, British Sign Language interpreter, easy read braille etc.)**

YES/NO

If NO please go straight to Medical Information on page 5.

<u>Please inform the surgery team if your needs change in the future.</u>

- **Do you consent for us to share your communication needs with other healthcare providers if required?**

YES/NO

The Accessible Information Standard (SCCI 1605 (Accessible Information))

Providers of health and adult social care services have new duties to support those who access their services who have sensory impairments and/or learning disabilities. They must:

1. **Identify** the communication and information needs of those who use their service;
2. **Record** the communication and information needs they have identified;
3. Have a consistent **flagging** system so that if a member of staff opens the individual's record it is immediately brought to their attention if the person has a communication or information need;
4. **Share** the identified information and communication needs of the individual when appropriate;
5. **Meet** the communication and information needs identified.

In accordance with The Accessible Information Standard (SCCI 1605 (Accessible Information)) please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual):

To help me communicate I use (e.g. a talking mat, hearing aids):

I need information in (e.g. braille, easy read):

If you need to contact me the best way is (e.g. email, telephone):

Medical Information

PAST MEDICAL HISTORY (IF ANY):

CURRENT MEDICATIONS

	YES / NO	COMMENT
DIABETIC		
ASTHMA		
DEPRESSION		
HIGH BLOOD PRESSURE		
Do you want help to lose weight?		
DO YOU SMOKE?		**If yes would like help to quit? YES / NO** **Have you ever smoked? YES / NO**

Please nominate a pharmacy for your prescriptions to be sent to ELECTRONICALLY:

Summary Care Record

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

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.

You have a choice

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.

Your options are outlined below; please indicate your choice on the form overleaf.

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

 Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

 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.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

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).

Name of patient: ……

Date of birth: …… Patient's postcode: ……

Surgery name: …… Surgery location (Town): ……

NHS number (if known): ……

Signature: …… Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ……

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare

Please now take this completed form along with the two forms ID (eg. Driving Licence/Passport/Utility Bill) to Reception.