



THE SPRINGS HEALTH CENTRE

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 name:

Middle name:

NHS No:

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Previous surname/s:

Male Female

Town & country of birth:

Home address:

Postcode:

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:

Do you have a carer? yes / no

If yes, please give their name and contact details:

Are you a carer? yes / no

If yes, please give the name and date of birth of person you care for:

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:

Leaving date:

Text reminder service



We send out appointment reminders and other reminders (for example, invites for annual reviews & flu vaccination clinics) by text message.

The signing of this form indicates your preference to receive text reminders. However, 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

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)



You probably already have a SCR (Summary Care Record). This 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. It contains information such as:

- Medicines you take
- Allergies you have
- Any medications that make you ill

This means that healthcare staff can provide safer care, whenever or wherever you need it, anywhere in England.

An SCR is optional and you can choose whether or not to have one. It will only be accessed with your permission except in exceptional circumstances, for example, emergency access if you are unconscious.

You can also choose to have other information included in your SCR, including:

- Your illnesses and any health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated
- What support you might need
- Who should be contacted for more information about you

The signing of this form indicates your preference to have an SCR with additional information. However, should you wish to opt out of having a summary care record with additional information please tick this box:

NHS Full Record Sharing



Are you aware that all the information we hold about your medical history is not automatically shared with other health care units? This means that if you attend another clinic or another unit they cannot currently see any of your information.

You have the opportunity to decide whether you want to share your medical records with other clinics. This system is called EDSM, the Enhanced Data Sharing Model. This will **not** apply to every clinic but only those who use the same clinical computer system as we do. Our system is called SystemOne. Sharing your records will enable the best possible care to be provided and it will mean that everyone caring for you is fully aware of your care plan and your medical history.

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:

Communication Method



Do you have any specific communication requirements owing to a disability, impairment or sensory loss, e.g. sight or hearing impairment etc.? YES NO

If yes, please specify:

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:



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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 (✓) <input type="checkbox"/>	Ex-smoker (✓) <input type="checkbox"/>	Current smoker (✓) <input type="checkbox"/>
	Year stopped <input type="text"/>	Quantity per day <input type="text"/>
	Quantity per day <input type="text"/>	

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.

- | | |
|---|---|
| <input type="checkbox"/> British or mixed British | <input type="checkbox"/> Bangladeshi or British Bangladeshi |
| <input type="checkbox"/> Irish | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Caribbean | <input type="checkbox"/> White and Asian |
| <input type="checkbox"/> African | <input type="checkbox"/> Other Asian background |
| <input type="checkbox"/> Indian or British Indian | <input type="checkbox"/> Other black background |
| <input type="checkbox"/> Pakistani or British Pakistani | <input type="checkbox"/> Other mixed background |
| <input type="checkbox"/> Polish | <input type="checkbox"/> 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)

Signature:

- Signature of patient signed: Date:
 Signature on behalf of patient

If signing on behalf of the patient, please print name & relationship to patient:

To be completed by the doctor

Doctor's name

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