**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:

 Address:

………………………………………………………………………………………………………………………………………………………………………………………………………..

Do you give consent for us to discuss your medical matters with the carer named above? yes / no / not applicable

………………………………………………………………………………………………………………………………………………………………………………………………………..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,** please give yourfirst 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:

**Accessible information standard:**

This question should be answered **only** by patients and carers with a disability, impairment or sensory loss.

Do you have any specific requirements **in connection with how we communicate with you** as a result of a disability, impairment or sensory loss? If so, please specify your wishes below:

An accessible means for us to contact you (e.g. telephone, email, text, letter)

…………………………………………………………………………………………………………………………………………………………………………………………………….

A suitable format of communication (e.g. non-standard print)

…………………………………………………………………………………………………………………………………………………………………………………………………….

Professional or other communication support (e.g. British Sign Language, carer)

…………………………………………………………………………………………………………………………………………………………………………………………………….

*Note for admin staff: Please add Accessible Information Standard data to the patient record using the link on the patient registration template. Please include a relevant patient reminder.*

**Text reminder service:**

We send out appointment and other reminders (for example, invites for annual reviews) by text message. This significantly reduces workload for the practice and provides more timely reminders for patients. We only send text messages in connection with your direct care. 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. On reaching the age of 12, children will normally be offered access to their own record following a short conversation with one of the doctors.**

**Electronic Prescribing**

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

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Your nominated pharmacy can be changed at any time.

**Smoking Data:**

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

Never smoked () Ex smoker () Current smoker()

 Year stopped Quantity per day

 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:

**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 normally shared with other NHS healthcare providers (where compatible IT systems are in place). This means that when you use other NHS services (like community physiotherapy, districts nurses etc) or when you attend some hospitals, the healthcare professionals are able to see your medical record. Conversely, when you receive treatment outside of the GP surgery, we are able to see details of your consultation (where compatible IT systems are in place). The other healthcare providers are only able to see your records during an active referral. Once the treatment has been concluded, they are no longer able to see your record.

If you do not want to allow record sharing, please tick this box:

**General Data Protection Regulations (GDPR):**

GDPR is an update of the Data Protection Act to provide increased protection for each individual's personal data. The GDPR requires us to process the data we hold on you fairly, lawfully & transparently. You can find out more details by reading our privacy notice. The notice explains what data we hold, what we do with it & why, who it goes to and the rights you have over it. You can also read our leaflet about “How We Use Your Information”. Both documents are available on the practice website www.thevalleysmedicalpartnership.nhs.uk or by requesting a copy from reception.

**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 |  | Bangladeshi or British Bangladeshi |
|  | Irish |  | Chinese |
|  | Caribbean |  | White and Asian |
|  | African |  | Other Asian background |
|  | Indian or British Indian |  | Other black background |
|  | Pakistani or British Pakistani |  | 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)

 ……………………………………………………………………..

**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: ………………………………

**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

 ………………………………………………………………………………………………..

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