



Hall Grove Group Practice

Hall Grove & Parkway Surgeries

Registration Pack - ADULT

First of all welcome to Hall Grove Group Practice. All of the forms you will need to register are within this pack and an explanation about each form and how it is used in our surgery.

Included in the pack (in order)

Family Doctor Services Registration

Registers you as being in our care with the NHS.

ADULT New Patient Registration Questionnaire

Tells us a bit about you the patient and any specific needs you may have. This is to help us whilst we wait to receive your medical records.

Online Services (Optional)

If you choose to register for online services you will be able request repeat medication and check or cancel doctor's appointment.

Summary Care Record

A summary care record can help by providing healthcare staff treating you the vital information from your health record.

WHEN RETURNING YOUR COMPLETED PACK

PLEASE BRING WITH YOU TO THE SURGERY

1. PROOF OF IDENTITY, SUCH AS A PASSPORT OR DRIVING LICENCE.
2. PROOF OF ADDRESS, SUCH AS AN UP TO DATE UTILITY BILL OR BANK STATEMENT.

Surgery Information and Opening Times

Parkway Surgery

20 Parkway
Welwyn Garden City
Herts
AL8 6HG
Tel: 01707 332233
Mon–Fri Doors open 8.30am – 6.30pm

Hall Grove Surgery

4 Hall Grove
Welwyn Garden City
Herts
AL7 4PL
Tel: 01707 328528
Mon–Fri Doors open 8.30am – 6.30pm

We operate extended hours surgeries, which include week day mornings, evenings and Saturdays. Please see online for further details or contact the surgery.

Home Visits phone line (323355) opens at 8am

We are online at hallgrovesurgery.co.uk

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 ☐ FemaleTown and country
of birth

Home address

Postcode

Telephone number

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

Your previous address in UK

Name of previous GP practice while at that address

Address of previous GP practice

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK,
date of leavingDate you first came
to live in UK

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

*Not all doctors are
authorised to
dispense medicines☐ I live more than 1.6km in a straight line from the nearest chemist☐ I would have serious difficulty in getting them from a chemist☐ Signature of Patient☐ Signature on behalf of patient

Date / /

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish☐ Any other white background (please write in):Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian☐ Any other Mixed background (please write in):Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi☐ Any other Asian background (please write in):Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian☐ Any other Black background (please write in):Other ethnic group: ☐ Chinese ☐ Filipino☐ Any other ethnic group (please write in):Not stated: ☐

Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only

Patient registered for

☐ GMS☐ Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date ____/____/____

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice
- b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
- c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:	Date:
Print name:	Relationship to patient:
On behalf of:	

Complete this section if you live in an EU country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:
		Country Code:
		3: Name
		4: Given Names
		5: Date of Birth
		6: Personal Identification Number
		7: Identification number of the institution
		8: Identification number of the card
		9: Expiry Date
PRC validity period (a) From:		(b) To:

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with Business Service Authority for the purpose of recovering your NHS costs from your home country.

Date Form Completed:

So that we can proceed with your registration with the minimum of delay, please complete this questionnaire as **FULLY** as possible. If you require assistance with this please contact the surgery.

NEW PATIENT HEALTH QUESTIONNAIRE

TITLE:		FIRST NAME:		
SURNAME:	CURRENT SURNAME:			
	PREVIOUS SURNAMES:			
DATE OF BIRTH:		GENDER:	M ☐ F ☐	(please tick)
OCCUPATION (If retired, your previous occupation)				
ADDRESS:				
		Postcode:		
HOME TEL:				
MOBILE TEL:				
WHO DO THESE DETAILS BELONG TO? (yourself / partner etc.)		HOME:		
		MOBILE:		
CAN WE LEAVE MESSAGES ON THESE NUMBERS?		MOBILE:	YES ☐ NO ☐	(please tick)
		HOME:	YES ☐ NO ☐	(please tick)
Would you like to register with the Practice for SMS text messages?		YES ☐ NO ☐	(please tick)	
PREVIOUS ADDRESS:		PREVIOUS GP's NAME & ADDRESS:		
Postcode		Postcode		
If you have children please list their names and ages:				
ARE YOU A CARER?			YES ☐ NO ☐	(please tick)
ARE YOU CARED FOR?			YES ☐ NO ☐	(please tick)
CONTACT NAME AND ADDRESS FOR ABOVE CARER				

HEALTH HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

HIGH BLOOD PRESSURE	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
ANGINA	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
HEART ATTACK	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
ATRIAL FIBRILLATION	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
ASTHMA	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
DIABETES	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
EPILEPSY	YES ☐ NO ☐ (please tick)	IF YES WHEN?	
UNDERACTIVE THYROID	YES ☐ NO ☐ (please tick)	IF YES WHEN?	

FAMILY HEALTH HISTORY

HAS ANY MEMBER OF YOUR FAMILY HAD ANGINA OR HEART ATTACK OR STROKE UNDER THE AGE OF 60? (please specify illness)

MOTHER:	YES ☐ NO ☐ (please tick)	IF YES, SPECIFY ILLNESS?	
FATHER:	YES ☐ NO ☐ (please tick)	IF YES, SPECIFY ILLNESS?	
SISTER:	YES ☐ NO ☐ (please tick)	IF YES, SPECIFY ILLNESS?	
BROTHER:	YES ☐ NO ☐ (please tick)	IF YES, SPECIFY ILLNESS?	

MEDICATION and ALLERGIES

DO YOU REGULARLY TAKE ANY MEDICINE OF ANY KIND, INCLUDING ANY THAT YOU BUY?	YES ☐ NO ☐ (please tick)
If you have a repeat prescription list please attach, if this is not available then please list below.	
If Yes, please tell us the name and dose: (Please continue overleaf if necessary)	
Medicine:	Dose:
Medicine:	Dose:
Medicine:	Dose:
Medicine:	Dose:
Medicine:	Dose:
Medicine:	Dose:
(Please note you may need to see the doctor for a first repeat prescription to be issued)	

ARE YOU ALLERGIC TO ANY MEDICATION?	YES ☐ NO ☐ (please tick)
If Yes, please state type and name:	
DO YOU HAVE ANY OTHER ALLERGIES?	YES ☐ NO ☐ (please tick)
If Yes, please state type and name:	

ELECTRONIC PRESCRIPTION SERVICE (EPS)	
The Electronic Prescription Service (EPS) is a NHS service that allows us to send your prescription/s directly to your chosen pharmacy. This paper-free prescription service means that you do not have to come into the surgery to collect the prescription.	
WOULD YOU LIKE TO REGISTER FOR EPS?	YES ☐ NO ☐ (please tick)
PLEASE STATE YOUR CHOSEN PHARMACY	

SMOKING AND ALCOHOL	
HAVE YOU EVER SMOKED?	YES ☐ NO ☐ (please tick)
If Yes, do you smoke now?: (You can receive help to give up smoking from the NHS Stop Smoking Service on 0800 389 3998)	If Yes, How much per day?
	If No, When did you give up?
HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL? (Please tick your answer)	
Never ☐	Monthly or less ☐
2-4 times per month ☐	2-3 times per week ☐
4 times a week or more ☐	
HOW MANY UNITS OF DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING?	
1 UNIT of alcohol = half pint beer or 1 glass wine or 1 single spirit (Please tick your answer)	
None, I don't drink ☐	1-2 ☐
3-4 ☐	5-6 ☐
7-9 ☐	10 or more ☐
HOW OFTEN DO YOU HAVE SIX OR MORE UNITS OR DRINKS ON ONE OCCASION? (Please tick your answer)	
Never ☐	Less than monthly ☐
Monthly ☐	Weekly ☐
Daily or almost daily ☐	

How we use your health records
The law determines how organisations can use the personal information they collect. Hall Grove Group Practice holds and uses the personal and confidential information of its patients for a number of purposes. For further information on the type of information we hold about you, what we use it for and also who we may share your information with please see our Privacy notice at www.hallgrovesurgery.co.uk.

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the

What is your main spoken language?

NAME

DOB

What is your main language?

Do you need an interpreter?

YES ☐ NO ☐ (please tick)

Do require a language interpreter

YES ☐ NO ☐
(please tick)

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White

British

Irish

Polish

Any other white ethnic group, please specify:

B. Mixed or multiple ethnic groups

Any mixed or multiple ethnic group

C. Asian, Asian British

Pakistani, or Pakistani British

Indian, Indian British

Bangladeshi, Bangladeshi British

Chinese, Chinese British

Other Asian, please specify:

D. African

African, African British

Other African, please specify:

E. Caribbean or Black

Caribbean, Caribbean British

Black, Black British

Other Caribbean or Black, please specify:

Other, please specify

If you would prefer not to provide this information, please tick here:

Information and Communication Needs, such as BSL interpreter or large print, are on the next page.

INFORMATION OR COMMUNICATION NEEDS
relating to a disability, impairment or sensory loss

Does your child (or your carer) have information or communication needs

YES ☐ NO ☐ (please tick)

This includes people who are blind, D/deaf or deaf/blind and people who have a learning disability

If YES, please complete the rest of this form. If NO, please sign the bottom of the form

Who is does this apply to?

Yourself

YES ☐ NO ☐ (please tick)

Carer

YES ☐ NO ☐ (please tick)

If you have any disability, impairment or sensory loss relating to information or communication needs please state:

When we write to you or contact you, do you need us to communicate in a particular way?

YES ☐ NO ☐ (please tick)

If YES, please tell us which way you would prefer us to communicate with you.

You may tick more than one box but please make your preference clear

By phone

YES ☐

I prefer to use the phone and I use a hearing aid

YES ☐

I prefer to use the phone and do not use a hearing aid

YES ☐

By email

YES ☐

If YES, please provide email address:

I use a screen reader

YES ☐

I do not use a screen reader

YES ☐

By text message

YES ☐

I use a text to speak app

YES ☐

I do not use a text to speak app

YES ☐

With Easy read pictures and words

YES ☐

By letter using large type

YES ☐

When you come into the surgery do you need a British Sign Language interpreter?

YES ☐

If you or your carer need anything that is not on the list above, please tell our receptionist when you come in for your next appointment and we will do our best to meet your needs

Can we share your information and communication needs with other NHS organisations, where this is appropriate for your healthcare

YES ☐ NO ☐ (please tick)

Patient's Signature (Please ensure normal signature as this will be checked against forms signed etc.)

FOR OFFICIAL USE:- Rev'd by:-
Doc's checked :

Confirming



HALL GROVE GROUP PRACTICE

Hall Grove & Parkway Surgeries

Dr Frances Cranfield
Dr A R J Parry
Dr Anthea Cecil
Dr Beata MacDougall
Dr P Shah
Dr M Benfield

Dr S Price
Dr C Thavamokankanthi
Dr Sadia Naseer
Practice Manager
Anne Knight

4 Hall Grove
Welwyn Garden City
Herts
AL7 4PL
Tel: 01707 328528

20 Parkway
Welwyn Garden City
Herts
AL8 6HG
Tel: 01707 332233

Online Repeat Medication ADULT Information and Application

Before you begin to use the repeat medication request service, please read the following information and attached agreement regarding the use of online services. **Please keep this leaflet for your own reference.**

A document containing your unique login username and password details will be posted five working days after the practice receives your signed agreement form (see attached). Please keep this document safe as it contains your personal information.

When registered you will be able to:

- Order Repeat Medication
- View appointments you have already booked
- Cancel appointments

Important points to consider before registering for access to online services

- **It will be your responsibility to keep your login details and password safe and secure.** If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

- **Choosing to share your information with someone:** It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
- **If you print out any information from your record,** it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.
- **Coercion:** If you think you may be pressured into revealing details from your patient record or allowing someone else direct access to your record against your will, it is best that you do not register for access at this time.

Repeat Medication Requests

On confirming your repeat medication request online your request is sent to the surgery and confirmation of your request appears on your home page. Your request is processed in the normal way, allow 3 working days.

Missed Appointments

If you are unable to attend your appointment please let us know as early as possible. You may cancel it online or telephone us. This will allow us to offer the appointment to another patient.

Inappropriate use

We are sure you will find this service useful. However, we will revoke your access to it if you abuse the service. For your access to be reinstated you must liaise with the Practice Manager.

Examples of what we would consider inappropriate use are:

- Requesting medication for other family members using your named account
- Using the optional message box for repeat prescriptions for anything other than medication

Medication for Family Members:

Unfortunately the system is not flexible enough to allow you to order medication for family members on your account. Separate accounts can be created for each family member. A patient agreement will need to be completed for each patient.

Registering your email or changing your password

When you choose to register your email address online we will receive your request to update your details. We have to manually update our clinical systems so please allow up to 5 working days.

You will still be able to use the online services in the meantime using the username and password on your letter.

You will be able to change your password online once you have received confirmation that your email address has been changed.

What do you need to do next?

Fully complete the Patient Agreement. When handing in your completed patient agreement to the receptionist proof of ID will be requested.

Patient Agreement for the use of Online Booking on next page >>

**Online Repeat Medication Services ADULT Application**

PLEASE COMPLETE FORM CLEARLY IN BLOCK CAPITALS

TITLE:		FIRST NAME:		
SURNAME:	CURRENT SURNAME:			
	PREVIOUS SURNAMES:			
DATE OF BIRTH:		GENDER:	M ☐ F ☐	(please tick)
OCCUPATION (If retired, your previous occupation)				
ADDRESS:				
	Postcode:			
HOME TEL:				
MOBILE TEL:				
WHO DO THESE DETAILS BELONG TO? (yourself / partner etc.)	HOME:			
	MOBILE:			
CAN WE LEAVE MESSAGES ON THESE NUMBERS?	MOBILE:	YES ☐ NO ☐	(please tick)	
	HOME:	YES ☐ NO ☐	(please tick)	
Would you like to register with the Practice for SMS text messages?		YES ☐ NO ☐	(please tick)	
YOUR EMAIL ADDRESS:				

(Admin note: Code to be added for online repeat medication requests – “Registered for online access to local practice”)

Your online log in details will be sent to your registered address.
Please allow a minimum of five working days.

I have understood and will adhere to the practice information leaflet for the use of Online Repeat Medication. I understand that failure on my part to adhere to the information regarding use may result in my online registration being terminated. I understand that this will in no way affect my registration with the practice.

Signed _____ Date _____

Administration Use only –

DATE _____ Photo ID seen _____ RECEPTION (name printed) _____

REQUESTING REPEAT MEDICATION

Apr 20

Hall Grove Group Practice

Welcome

You last successfully signed on 14 minutes ago.

WE CURRENTLY OFFER ONLINE ACCESS FOR DOCTORS APPOINTMENTS

IF YOU WANT TO CHANGE YOUR PASSWORD PLEASE ADD A UNIQUE EMAIL ADDRESS

Your Appointments

You have no appointments booked, do you want to [book an appointment now?](#)

What you can do

- [Book new appointment](#)
- [Repeat my medication](#)
- [Change my details](#)
- [Change my password](#)
- [Logout](#)

NHS Links

- [NHS Direct](#)
- [Search for Local Services](#)
- [Common Health Questions](#)
- [NHS Direct Check your symptoms](#)

CLICK ON REPEAT MY MEDICATION

Apr 21

Hall Grove Group Practice

Request a Repeat Prescription

Important notice to all patients

Please note that when changes are made to your prescribed medication by your GP or Nurse Practitioner, there may be a delay in these changes being reflected in your repeat medications list within Appointments Online. If you are in any doubt about the accuracy of your repeat prescription, please contact your GP surgery

Select the medications to repeat

☒ Aspirin 75mg dispersible tablets

I would like to pick my prescription up from

Enter an optional message for the practice

HALL GROVE SURGERY
HALL GROVE SURGERY
PARKWAY SURGERY
PHARMACY - ALREADY SET UP WITH SURGERY

TICK TO SELECT MEDICATION REQUIRED

SELECT PRESCRIPTION COLLECTION LOCATION
Hall Grove Surgery, Parkway Surgery or pre-arranged pharmacy

CLICK ON CONFIRM REPEAT MEDICATION

or [Go back to my home page without sending it](#)

Message from webpage

? Please confirm you wish to request the following for repeat prescription:

Aspirin 75mg dispersible tablets

To be picked up from HALL GROVE SURGERY

Do you wish to continue?

CONFIRM OR CANCEL REQUEST

Welcome

You last successfully signed on 14 minutes ago.

WE CURRENTLY OFFER ONLINE ACCESS FOR DOCTORS APPOINTMENTS

IF YOU WANT TO CHANGE YOUR PASSWORD PLEASE ADD A UNIQUE EMAIL ADDRESS

Your Appointments

You have no appointments booked, do you want to [book an appointment now?](#)

Your Recent Repeat Medication Requests

On the 20-04-2015 at 11:52 you requested the following medications:

- Aspirin 75mg dispersible tablets
1. Collect from Hall Grove surgery please

[Make another request](#)

Your Details

No email address set. This is used to reset your password. [Add one now?](#)

User name
NHS number
Name
Address
e-mail

What you can do

- [Book new appointment](#)
- [Repeat my medication](#)
- [Change my details](#)
- [Change my password](#)
- [Logout](#)

NHS Links

- [NHS Direct](#)
- [Search for Local Services](#)
- [Common Health Questions](#)
- [NHS Direct Check your symptoms](#)

ON CONFIRMING YOUR REPEAT MEDICATION REQUEST

YOUR REQUEST IS SENT TO THE SURGERY AND CONFIRMATION OF YOUR REQUEST CAN BE SEEN ON YOUR HOME PAGE.

YOUR REPEAT REQUEST IS THEN PROCESSED IN THE NORMAL WAY, **ALLOW 3 WORKING DAYS.**

UNABLE TO SELECT YOUR REPEAT MEDICATION?

Likely causes:

- YOUR MEDICATION REVIEW DATE IS OVERDUE
- THE DOCTOR HAS NOT ADDED THE MEDICATION TO YOUR REPEAT LIST.
Please add medication in the optional message box if you think a medication should be on repeat but does not appear. **Please add a telephone number we can contact you on.**
- YOUR REPEAT MAY HAVE JUST BEEN SET UP ON OUR SYSTEM. If a doctor has just added your medication to your record you will need to wait for an overnight feed before it can be seen online.

The optional message box is only for prescription/medication requests

YOU MAY ONLY REQUEST YOUR MEDICATION (NOT MEDICATION FOR ANYONE ELSE) ON YOUR NAMED ACCOUNT

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COP) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

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:

Address:

Postcode: Date of Birth:

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

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

Information for new patients: about your Summary Care Record

Dear Patient,

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.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

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.

- a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
- b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.
- c) **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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.