Hall Grove Group Practice

Hall Grove & Parkway Surgeries

Registration Pack - CHILD

First of all welcome to Hall Grove Group Practice. All of the forms you will need to register are within this pack.

Forms included in the pack (in order)

Family Doctor Services Registration
Registers you as being in our care with the NHS.

New Patient Registration Questionnaire – Under 16 Year olds
Tells us a bit about the patient and any specific needs they may have. This is to help us whilst we wait to receive your child's medical records.

Registration of Child/Young Person
The form is for the use of the Health Visitors and sent to them by the surgery.

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 CHILD'S COMPLETED PACK

PLEASE BRING WITH YOU TO THE SURGERY

1. **PROOF OF YOUR CHILD'S IDENTITY**, SUCH AS A PASSPORT, BIRTH CERTIFICATE OR RED BOOK
2. **Registering a new baby** we ask that you bring along the mother and baby discharge from hospital.
3. **PARENT'S PROOF OF ADDRESS***, SUCH AS AN UP TO DATE UTILITY BILL OR BANK STATEMENT

*This is needed for online services

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

NHS Family doctor services registration GMS1

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 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 leaving

Date 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

NHS Family doctor services registration

GMS1

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:**	DD MM YY
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	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

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:	

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

NEW PATIENT HEALTH QUESTIONNAIRE (under 16 years old)

TITLE:		**FIRST NAME:**	
CURRENT SURNAME:			
PREVIOUS SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS :		**WHO ELSE LIVES IN THIS HOUSEHOLD?**(please tick all those that apply)	
Postcode:		Mum ☐ Dad ☐ Step parent ☐ Parent's partner ☐ Grandparents ☐ Brothers and sisters ☐ how many? ☐ Foster carer ☐ guardian ☐ Others- please state	
HOME TEL: Mum/Dad, etc.			
MOBILE TEL: Mums or Dads,etc			
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**MOBILE:**	**YES** ☐ **NO** ☐ (please tick)	
	HOME:	**YES** ☐ **NO** ☐ (please tick)	
Would you like to register with the Practice for SMS text message reminders, regarding medical needs?		**YES** ☐ **NO** ☐ (please tick)	

ONCE YOUR CHILD IS 16 YEARS OLD YOUR MOBILE PHONE NUMBER AND YOUR E-MAIL ADDRESS WILL BE REMOVED FROM THEIR MEDICAL RECORDS.

WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD?
Please tell us their name, contact details *(if not given above)* and their relationship to the child

PREVIOUS ADDRESS:	PREVIOUS GP's NAME & ADDRESS:

HEALTH HISTORY	
HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS? There is additional space on the back of this form if required	**YES** ☐ **NO** ☐ (please tick)
If Yes, what was this and when? :	
DOES YOUR CHILD HAVE A DISABLITY OR CHRONIC CONDITION?	**YES** ☐ **NO** ☐ (please tick)

DOES YOUR CHILD HAVE (Please Tick)					
ASTHMA		**DIABETES**		**THYROID DISEASE**	
HIGH BLOOD PRESSURE		**EPILEPSY**		**HEART DISEASE**	

FAMILY HISTORY					
ASTHMA		**DIABETES**		**GLAUCOMA**	
BLINDNESS		**TUBERCULOSIS**		**HEART DISEASE**	
INFECTIOUS DISEASES		**OTHERS (please specify**			
MENTAL HEALTH ISSUES					
CANCER		**Type of Cancer (if known)**			

MEDICATION and ALLERGIES

IS YOUR CHILD ON ANY REGULAR MEDICATION?	YES ☐ NO ☐ (please tick)

If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy)

(Please note your child may need to see the doctor for a first repeat prescription to be issued)

IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	YES ☐ NO ☐ (please tick)

If Yes, please state type and name:

DOES YOUR CHILD 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 child's 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	

Which school or nursery does your child attend?

Does your child have contact with any of the following? *(if so please can you tell us their names)*

A hospital specialist? YES ☐ NO ☐ (please tick)
A health visitor? YES ☐ NO ☐ (please tick)
A social worker? YES ☐ NO ☐ (please tick)
Any other health professionals? YES ☐ NO ☐ (please tick)

Has your child ever been under a Child Protection Plan?	YES ☐ NO ☐ (please tick)

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 if for and also who we may share your information with please see our Privacy notice at www.hallgrovesurgery.co.uk.

It is important that your child's immunisations are kept up to date.
A current photocopy of the immunisation history (this can be found in the child's 'Red Book') will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS	DATE GIVEN
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib ***(5 in 1)***	
OR 1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib, *HepB** ***(6 in 1)***	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib ***(5 in 1)***	
OR 2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, *HepB** ***(6 in 1)***	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib ***(5 in 1)***	
OR 3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, *HepB** ***(6 in 1)***	

	DATE GIVEN		DATE GIVEN
1st Rotavirus**		2nd Rotavirus**	
1st Pneumococcal		2nd Pneumococcal	
1st Meningitis B		2nd Meningitis B	
3rd Meningitis B			
1st Meningitis C			
Hib/ Meningitis C 1st Measles, Mumps, Rubella (MMR) Booster Pneumococcal			
Booster Diphtheria, Tetanus, Whooping Cough, Polio Booster Measles, Mumps, Rubella (MMR)			
Details of any other immunisations:			

* *Hep B – Hepatitis B included since Autumn 2017*
** *Rotavirus included since 2012*

IMPORTANT:

All the information given to the Practice as part of this form will be treated as Confidential.
However to give your child the very best health care we work closely with the Health Visiting and School Nursing Service.
It is therefore our normal Practice to share the details of all children registering with the Practice with our NHS colleagues in Health Visiting and School Nursing.

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

NAME _____ **DOB** _____

What is your main language?

Do you need an interpreter? **YES** ☐ **NO** ☐ (please tick)

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

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

Does your child (or their parent/guardian) 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?	Child	YES ☐ NO ☐ (please tick)
	Parent/Guardian	YES ☐ NO ☐ (please tick)
If your child 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 your child comes into the surgery do they, or you, need a British Sign Language interpreter?		YES ☐
If you or your child's 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 child's information and communication needs** with other NHS organisations, where this is appropriate for their healthcare		YES ☐ NO ☐ (please tick)

Parent / Guardian's Name	
Parent / Guardian's Signature (Please ensure normal signature as this will be checked against forms signed etc.)	

Registration of Child/Young Person (0-16)

Please complete all sections clearly in black ink

Name_____Sex M / F

Date of Birth___ /____ /_____GP Surgery_____.

Current Address_____

_____.

Day time contact no_____Evening contact no _____.

School/ Nursery_____

Ethnic Group_____*please enter Ethnic Group code (see table)*

First Language_____Religion _____.

Main Carer_____Relationship_____.

Form Completed by_____Date____ /_____ /_____.

If applicable:

Previous Address_____

_____.

Previous GP Surgery _____.

Previous School_____.

Thank you. This information will be shared with The Primary Health Care Team

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FOR HV/SHN USE ONLY:

Information Received_____ /_____ /_____.

Records request form_____on____ /_____ /_____.

Information sent to child/school Heath_____ /_____ /_____

Hertfordshire Community NHS
NHS Trust

ETHNIC GROUP CODES

Please enter your ethnic group code in the space provided on the left of this form

ETHNIC GROUP	CODE
White	
British	A
Irish	B
Any other white background	C
Mixed	
White & Black Caribbean	D
White & Black African	E
White & Asian	F
Asian or Asian British	
Indian	H
Pakistani	J
Bangladeshi	K
Any other Asian Background	L
Black or Black British	
Caribbean	M
African	N
Any other Black background	P
Other Ethnic Groups	
Chinese	R
Any other Ethnic Groups	S

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 CHILD Information and Application

Before you begin to use the online booking or repeat medication request service, please read the following information and attached agreement regarding the use of online services. **Please keep this information 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 and detach the Patient Agreement. When handing in your completed patient agreement to the receptionist proof of photo ID will be requested.

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

Hall Grove Group Practice

Hall Grove & Parkway Surgeries

Online Repeat Medication CHILD Services Application

PLEASE COMPLETE FORM **CLEARLY IN BLOCK CAPITALS**

TITLE:		**FIRST NAME:**	
SURNAME:	**CURRENT SURNAME:**		
	PREVIOUS SURNAMES:		
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS:	**Postcode:**		
HOME TEL:			
MOBILE TEL:			
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (child/ 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)	

Once your child is 16 years old your mobile phone number / e-mail address will be removed from their medical records.

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 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 _____

*Signed by Parent or Guardian

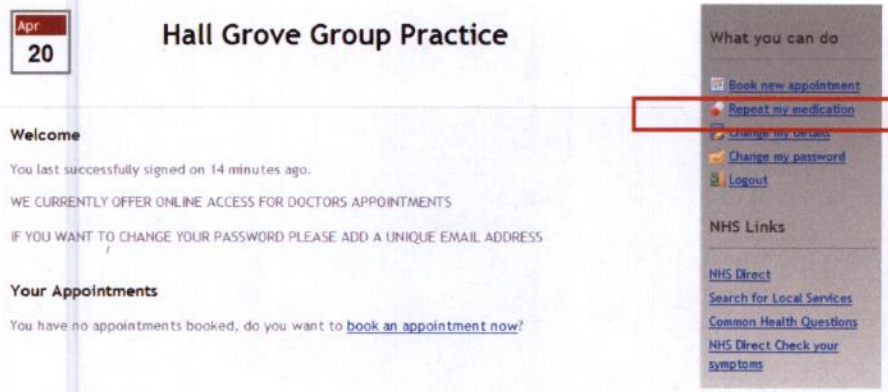
Name of Parent or Guardian _____

If a Parent or Guardian registers on behalf of a child who is under 16, this access will be revoked once the child reaches the age of 16.

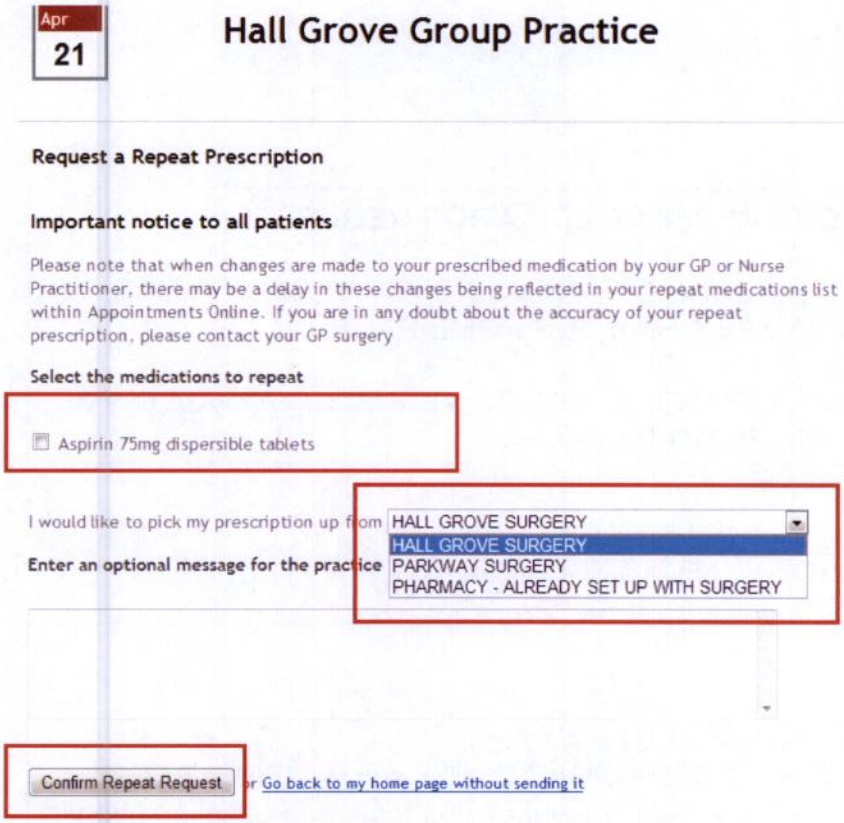
Administration Use only –

DATE_____ **Photo ID seen**_____ **RECEPTION (name printed)** _____

REQUESTING REPEAT MEDICATION



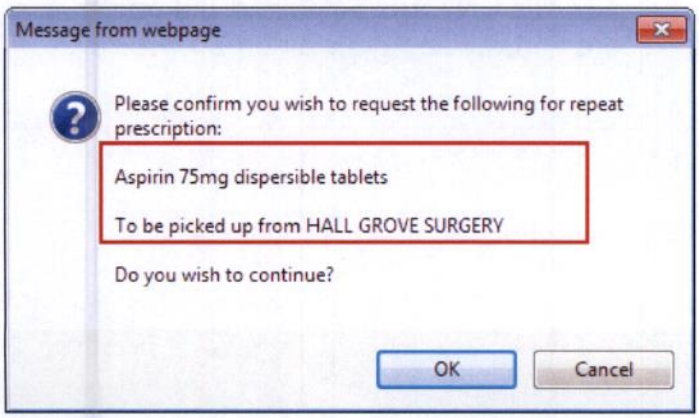
CLICK ON REPEAT MY MEDICATION



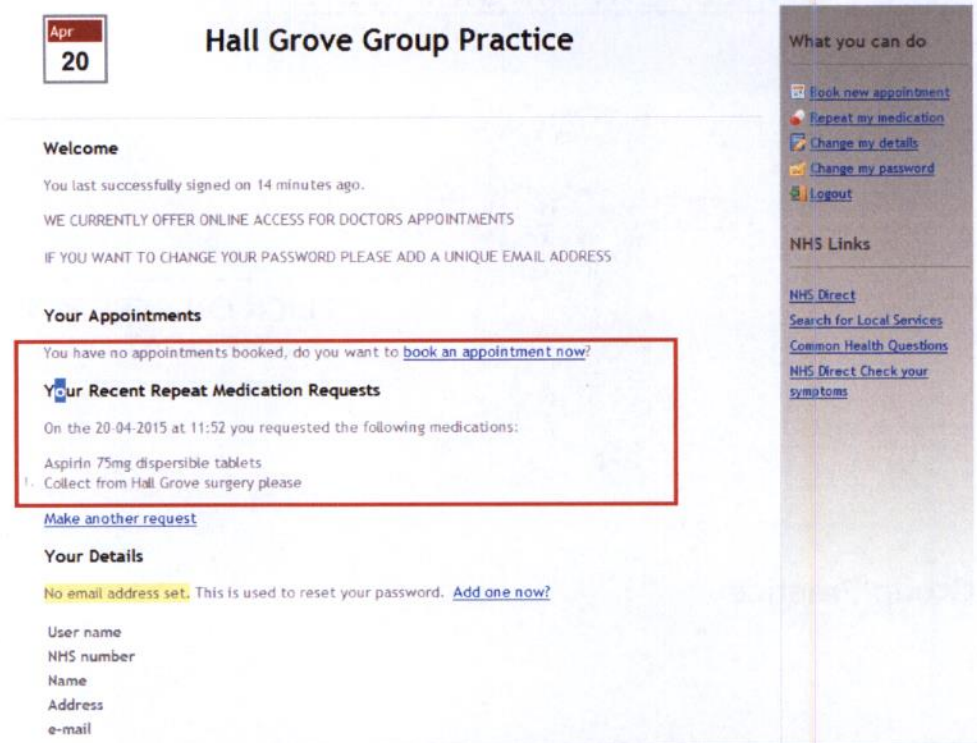
TICK TO SELECT MEDICATION REQUIRED

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

CLICK ON CONFIRM REPEAT MEDICATION



CONFIRM OR CANCEL REQUEST



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

NHS Digital

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 (COPI) 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.

NHS Digital

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.