Welcome to The Old Dairy Health Centre

Registration for under 16's

As it can take several weeks before we receive your medical records please respond to the following questionnaire.

PLEASE WRITE YOUR DETAILS IN CLEAR BLOCK CAPITALS

FOR OFFICE USE	
Checked by:	
Date:	
Parent(s) Registered	
Catchment Area	
Telephone No.	
Email Details	
Previous GP	
Previous Address	
Ethnicity	
Main Language	
Family History	
Smoking Status	
Alcohol	
Height/Weight	
Patient Consent	
Inform Named GP	
EPS	
HIV Test	
All form complete	

Full Name: ______________________________________

Date of Birth: ___/___/_______

Address: ____

Post Code: _______ _______

Landline Number:

Mobile Number:

CONTACT DETAILS	
Mother's Name:	Tel No.:
Father's Name:	Tel No.:
Guardian's Name (*If applicable*):	Tel No.:
Please give details of your Nursery/School:	
Name of Nursery/School:	
Name of Principal/Teacher:	
Address of Nursery/School:	
Tel No. of Nursery/School:	
Is your child currently under the care of Social Services?	Yes ☐ No ☐
If yes, please give name and contact number of Social Worker: Name: Tel:	

Email Address:

PLEASE BRING YOUR **CHILD'S REDBOOK** WITH THIS REGISTRATION FORM.

ETHNICITY - please indicate the ethnic group to which you feel you belong:					
White		**Black**		**Asian**	
☐	British	☐	African	☐	Bangladeshi
☐	Irish	☐	Caribbean	☐	Indian
☐	Other White Background	☐	Black British	☐	Pakistani
Mixed Background		☐	Other Black Background	☐	Asian British
☐	White/Black Caribbean	**Other Backgrounds**		☐	Chinese
☐	White/Black African	☐	Chinese British	☐	Other Asian Background
☐	White/Asian	☐	Vietnamese British	☐	Vietnamese

RELIGION	
What religion are you?	Religion None ☐

LANGUAGE	
What is your main spoken language? What language do you prefer to read?	
Do you have difficulty hearing, or need hearing aids; or need to lip-read what people say?	Yes ☐ No ☐
Do you have difficulty with memory or ability to concentrate, learn or understand?	Yes ☐ No ☐
Can you read English?	Yes ☐ No ☐
Do you have difficulty speaking or using language to communicate or make your needs know?	Yes ☐ No ☐
What is the best way to send you information? Telephone☐ Text relay☐ SMS☐ Letter☐ Email☐ Other:	
Do you need a format other than standard print? Yes☐ No☐ (If yes, which of the following?) Braille☐ Electronic audio format☐ Easy Read☐ Large Print☐ Other:	
Do you need the assistance of a Communication Professional? Yes☐ No☐ (If yes, which of the following?) Interpreter☐ Interpreter for Deaf-Blind people☐BSL Interpreter☐ Makaton Interpreter☐ Notetaker☐ Tadoma Interpreter☐ Lipspeaker☐ Sign Language Translator☐ Speech to Text Reporter☐	
Do you need an advocate? (Someone to support you communicate or express your point of view) Yes ☐ No ☐ (If yes, please state their name and relationship to you):	

MEDICATION: Are you on regular medication? If so, please list the names of the medication, dosage and how often you take them, or **attach a list of your medication from your previous surgery**.

Medication Name	Dosage/How Often

The **ELECTRONIC PRESCRIPTION SERVICE (EPS)** is a NHS Service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from. Your prescription will be sent electronically to the pharmacy of your choice. **This means you will not need to come into the surgery to collect your prescription** as it will be prepared and ready for collection at your chosen pharmacy.
PLEASE NOTE THAT THIS DOES NOT APPLY TO PATIENTS WITH A DOSSETT BOX OR PATIENTS WHO ARE ON A CONTROLLED MEDICATION.
For more information about EPS visit www.cfh.nhs.uk/eps or ask one of our receptionists.

Would you like to **subscribe to EPS** or have you previously nominated a pharmacy to send your prescription electronically to?	Yes ☐	No ☐
If yes please provide the name of your nominated pharmacy and their **POST CODE**:		

MEDICAL HISTORY - Please give details of the following if applicable:		
	Year(s)	**Details**
Operations	____________	____________
Injuries/Fractures	____________	____________
Illnesses	____________	____________
Anaesthetics	____________	____________

Do you have a family history of: (please tick)	**Mother**	**Father**	**Sister**	**Brother**	**Aunt**	**Uncle**	**Maternal**		**Paternal**	
							Grand Mother	**Grand Father**	**Grand Mother**	**Grand Father**
Heart disease										
Angina										
Hypertension										
Diabetes										
Asthma										
Epilepsy										
Dementia										
Depression										
Glaucoma										
High cholesterol										
Stroke/TIA										
Thyroid Disease										
Mental Health Issues										
Kidney Disease										
Lung disease										
Learning Disabilities										
Cancer (*please state which type)*										

ALLERGIES: are you allergic to any medication, food, animals, etc.? **Yes**☐ *(please state which)* **No**☐	

ONGOING MEDICAL PROBLEMS						
Stroke☐	Asthma ☐	Cancer ☐	Diabetes ☐	Epilepsy ☐	Angina ☐	Mental Health Issues ☐
Glaucoma ☐	Heart Disease ☐	High Blood Pressure☐	High Cholesterol ☐	Thyroid Disease ☐		
Kidney Disease ☐	Learning disabilities ☐	Depression ☐	Lung Disease ☐	Dementia ☐		
Other (Please give details):						

DIET: How healthy is your diet? Poor ☐ Average ☐ Good☐	
How many portions of fruit/vegetables/salad do you eat per day?	
Do you eat fried food regularly?	Yes ☐ No ☐
Do you drink plenty of water?	Yes ☐ If yes how may glasses/Litres per day?__________ No ☐
Do you drink coffee?	Yes ☐ If yes how many cups per day?___________ No ☐
Do you have a special diet, i.e. low salt, vegetarian, vegan, gluten free?__________________________	

EXERCISE: Do you take regular exercise?	**Yes** ☐ **No** ☐
If yes, please state what kind and how often: ____	

WEIGHT:______Kg or _____st_____lbs	**HEIGHT:**______cm or _____feet_____inches

CHILDREN	
Do you have any children? Yes ☐ No ☐	
If 'Yes', how many?____________________________How old are they?_________________________ Do your children live with you? Yes ☐ No ☐ Are they registered with our Practice/going to be registered with our Practice? Yes ☐ No ☐ If 'No' please give name of Practice where registered ………………………………………………..	

HIV TEST			
It is Practice policy to offer all new patients an HIV test. If you decided you would like a test, we will contact you shortly. If you are unsure and would like to speak to someone, we will arrange a telephone consultation with a clinician for you to discuss this further.			
Do you wish to have an HIV test?	Yes ☐	No ☐	Not sure ☐

CARERS	
Are you a Carer? (Do you care for an elderly or disabled person?	Yes ☐ No ☐
Are you Cared for?(Are you elderly or disabled and need a friend/relative to help you live your daily life?)	Yes ☐ No ☐

PATIENT CONSENT		
Do you give consent for the Practice to leave you messages on your **ANSWERPHONE**?	I give consent ☐ I **do not** give consent ☐	Mobile ☐ Landline ☐ Both ☐
Do you give consent for the Practice to contact you via **TEXT/SMS?**	I give consent ☐ I **do not** give consent ☐	Mobile ☐ Landline ☐ Both ☐
Do you give consent for the Practice to contact you via **EMAIL?**	I give consent ☐ I **do not** give consent ☐	
Do you give consent for the Practice to leave messages with a (family member/friend/carer)?	I give consent ☐ I **do not** give consent ☐	Please state their name(s) and relationship to you:___________ ____________________________
Do you give consent for the Practice to give your prescription to a (family/member/friend/carer)?	I give consent ☐ I **do not** give consent ☐	Please state their name(s) and relationship to you:___________ ____________________________ ____________________________

SUMMARY CARE RECORD Your Summary Care Record (SCR) is an electronic summary of your key health information. It includes any medicines you are taking and any allergies you may have. **Your SCR will help healthcare staff to care for you in an emergency or when your GP Practice is closed.**	I consent to a Summary Care Record ☐ I **do not** consent to a Summary Care Record ☐
LOCAL CARE RECORD The Local Care Record enables healthcare professionals to view your medications, previous treatments, test results and any other clinical information electronically between your GP Practice and Guy's and St Thomas', King's College Hospital and South London and Maudsley. Information is only shared when it is needed to make your care and treatment safer, easier and faster and only with those people directly involved in your care.	I consent to a Local Care Record ☐ I **do not** consent to a Local Care Record ☐
PATIENT PARTICIPATION GROUP Our PPG consists of members who attend our meetings and those who just wish to be kept informed via email.	Would you like to become a PPG member? Yes ☐ No ☐

Did someone help you to complete this form?	Yes ☐ No ☐

Patient's Signature:____________________________________ **Date:**____/____/_______
(I declare that the information I've given above is accurate and truthful)

For Office Use Only:

Registration Information Entered on Computer	*Name:*	*Date:*

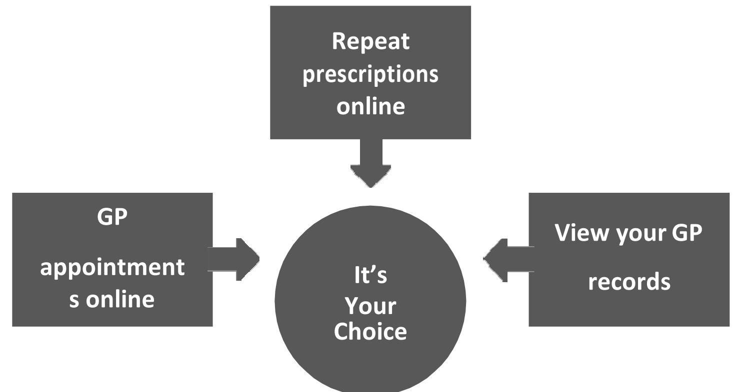
Online Services Records Access
Patient information leaflet 'It's your choice'

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

Subject to approval of your Online Service Registration Form, you will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.



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.

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.

If you would like to register for Online Access, please complete the attached form and return it to reception. You will be asked to show photo ID before being registered.

If you would like someone to help you set up Patient Access and show you how to use it, please book an appointment with one of our Senior Administrators Tania or Zoe.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Things to consider	
	Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
	Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
	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.
	Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
	Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
	Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information
For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:
Keeping your online health and social care records safe and secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf

Rosendale Surgery

Application for online access to my medical record via Patient Access

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply)

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only

Patient NHS number:		Practice computer ID number:
Identity verified by (initials):	Date:	Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Date account created:		Date passphrase sent:

Authorised by	Date
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐	**Notes / explanation**