Do you have any special communication needs? 🞏 Yes 🞏 No

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other …………………………………………………………….

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**:  Mr  Mrs  Miss  Ms  Male  Female

Date of Birth (day/month/year) NHS Number 

Town & country of Birth

 Post Code:

Address

Telephone number: Home Mobile number:

Preferred number : Home Mobile

Email address:

Your contact details will be used for adminstration purposes, such as sending texts/emails about appointments, routine tests, reminders. If you do not want your details to be used for these purposes, plesae speak to a member of our Reception team.

**You will be allocated and informed of a named GP. This will be Dr James Downie.**

***You are however entitled to make an appointment with any GP of your choice, subject to availability.***

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

Your previous address in UK

 Post Code:

Name of previous Doctor

while at that address

 Post Code:

Address of previous Doctor

Where did you last receive Date:

treatment?

*ie GP, Walk in Centre, MIU, Emergency Department etc*

What was the outcome of

this visit? ie prescription

**If you are from abroad:**

Your first UK address where

 Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

**If you need your doctor to dispense medicines & appliances\*:**

For Dispensing Practices only:

Please tick to collect any prescribed medication from the surgery.

**Armed forces details**

Enlistment date

 Post Code:

Leaving date Service/Personel No’

**Register as a Military Veteran**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**:  Mr  Mrs  Miss  Ms  Male  Female

I confirm that I am happy for this to be annotated to my medical record. Y N

**NHS Organ Donor registration:**

Practices will no longer be able to record this information from the 1st October 2021 and patients should visit the organ donation website to [make their choices](https://www.organdonation.nhs.uk/register-your-decision/). If you would like to speak to somebody about your choices, please call the NHS dedicated line: **0300 303 2094.**

**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 🞏

**Online services**

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 |  |

1. 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 |  |

Burbage Surgery Consent to Share Information (NOT APPLICABLE FOR UNDER 14)

I give permission for Doctors and staff at Burbage Surgery to communicate all relevant medical information and test results with the persons listed below.

Name:………………………………………. Relationship to patient :…………………………………..

1)

2)

This permission relates to all / part of my records. (Delete as appropriate)

* I consent to these persons receiving copies of correspondence relating to my treatment. 
* I authorise these persons to collect medication, prescriptions or controlled drugs on my behalf 
* I acknowledge that I may withdraw this consent at any time by notifying the surgery in writing 

 .

I confirm that I am happy to receive text messages including:

* appointment details 
* health campaigns such as smoking, flu vaccinations & NHS Health Checks 
* test results 

By providing your email details you are consenting to the Practice contacting you in this way.

If you do not wish to be contacted by email or text then please tick this box. 

Signed:…………………………………………………… Date: ……………..

**SUMMARY CARE RECORDS – PLEASE READ CAREFULLY**

We offer our patients the choice of having a Summary Care Record. (SCR) This is separate from your health record and is created automatically. It was introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with. **We strongly recommend this**.

The SCR contains basic information including:

**. Your name, address, date of birth and NHS number**

**. Current medication**

**. Allergies and details of any previous bad reactions to medicines**

The Intention is to help clinicians in A&E Departments and ‘Out of Hours’ health services (eg Ambulance service) to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, **Only if you give your express permission**. You will be asked if healthcare staff can look at your SCR every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

**Patients under 16 years will have SCR created for them unless their GP surgery is advised**

**If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

I, (Print Name)…………………………………………. (Date of Birth) ………………….

I DO WANT A SUMMARY CARE RECORD

I DO NOT WANT A SUMMARY CARE RECORD

With your consent, additional information can be added to create an Enhanced SCR. This could include details of long-term conditions, significant medical history, or specific communications needs, to help ensure you receive the appropriate care in the future.

If you do NOT want an Enhanced SCR please tick 

Signed ………………………………………….. Dated..…………………………..

For more information visit <https://digital.nhs.uk/services/summary-care-records-scr>

**Please tell us about yourself:**

Are you an informal carer? 🞏 Yes 🞏 No Do you have a carer? 🞏 Yes 🞏 No

If yes, please tell us the name & address of your

Carer:

Are you happy for us to contact your carer 🞏 Yes 🞏 No

about you?

**For patients aged 85 or over: (these are to help us assess if you may need additional clinical input)**

In general, do you have any health problems that require you to limit your activities?  🞏 Yes 🞏 No

In general, do you have any health problems that require you to stay at home?   🞏 Yes 🞏 No

Do you regularly use a stick, walker or wheelchair to get about?     🞏 Yes 🞏 No

In case of need, can you count on someone close to you?    🞏 Yes 🞏 No

Do you need someone to help you on a regular basis?    🞏 Yes 🞏 No

Please provide details if the person is different

from the information you have provided as your carer.

**Personal Medical History…..**

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing**  |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations ……**

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Year** | **Immunisation** | **Year** |
| Tetanus |  | Polio |  |
| Typhoid |  | Yellow Fever |  |
| Hepatitis A |  | Hepatitis B |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication/food etc:

|  |  |
| --- | --- |
| **Name of medication/Drugs/any allergies**  | **What was the problem or upset?** |
|  |  |
|  |  |
|  |  |
|  |  |

If you have a copy of your repeat medications, please attach to this form

please pass to Reception to copy

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Lifestyle ……**

Please enter your height & weight:

|  |  |
| --- | --- |
| Height: | Weight: |

**Lifestyle smoking ……**

Do you smoke: 🞏 Yes 🞏 No If yes, do you

smoke: 🞏 Cigarette 🞏 Cigars 🞏 Pipe

Are you an ex-smoker?  Yes  No When did you give up?

How many cigarettes/ 🞏 <1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

cigars do you smoke

daily?

If you smoke a pipe Would you like help  Yes  No

how many ounces a to quit smoking?

week?

**Lifestyle alcohol ……**

Do you drink alcohol:  Yes  No If yes, please answer the following questions:

How often do you have a drink that contains 🞏 Never 🞏 Monthly 🞏 2-4 times 🞏 2-3 times 🞏 4+ times

alcohol? Or less per month per week per week

How many standard alcoholic drinks do you 🞏 1-2 🞏 3-4 🞏 5-6 🞏 7-8 🞏 10+

have on a typical day when you are

drinking?

How often do you have 6 or more standard 🞏 Never 🞏 Less than 🞏 Monthly 🞏 Weekly 🞏 Daily

drinks on one occasion?

**Lifestyle exercise ……**

Do you exercise: 🞏 Yes 🞏 No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

**Female patients only ……**

**vej**

Are you currently, or think you may be 🞏 Yes 🞏 No

pregnant?

Do you have any children?  Yes  No If yes, how many?

Which method of contraception (if any) are

you using at present?

Have you had a cervical smear test?  Yes  No If yes, what was the

 result? (if known)

 Date if Known :

**Ethnicity ……**

**vej**

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

 Bangladeshi  Chinese  Other (please state):

🞏 Decline to state

**Next of kin ……**

**vej**

Name: Tel. contact

 number:

Relationship:

**Signature ……**

**vej**

**Patient Declaration for all patients who are not ordinarily resident in the UK**

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient 🞏 Signature on behalf of patient 🞏

****