Dalton Surgery
364a Wakefield Road
Dalton
Huddersfield
HD5 8DY
www.daltonsurgeryhuddersfield.com
Tele: 01484 530068

Welcome to Dalton Surgery – Nursing/Care Home

Please read this questionnaire carefully, complete in BLOCK CAPITAL LETTERS and sign in full.

Failure to do this will result in the form being returned to you.

Thank you for your co-operation during these uncertain times.

Please bring with you, where possible, copies of:

- A printed medication list (the right-hand side of a recent prescription - if you have regular medication)

Please tell us of any medical problems you are concerned about, and a routine telephone appointment can be made with a GP once you are registered.

Thank you

Dalton Surgery

364a Wakefield Road, Huddersfield, West Yorkshire, HD5 8DY
Phone: 01484 530068

New Patient Registration

About You

Surname: ………………………………………….. Forename(s): …………………………………………………

Date of Birth (dd/mm/yyyy): …………………….….... Gender: …………………………………………………

Contact Information

Address:……..

Telephone: ………………………………………… Mobile: ……………………………………………………

Email: ……

Previous UK address (if applicable):……………………………………………………………………………

Residential Status

Do you live a residential home?	**Yes**	☐	**No**	☐
Do you live a nursing home?	**Yes**	☐	**No**	☐
Do you live in a supported home?	**Yes**	☐	**No**	☐
Do you live in a care home?	**Yes**	☐	**No**	☐

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.
Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

Preferred Title

How would you like us to refer to you (eg Mr, Mrs, Miss, Mx)?...

Religious Affiliation

Do you have a religious affiliation (please give details if so)?..

Country of Birth

In which country were you born?...

Language

Which is your main language?...

Do you speak English? **Yes** ☐ **No** ☐

Do you need an Interpreter? **Yes** ☐ **No** ☐

Next of Kin

1. Title: ……… Surname: ………………………………… Forename(s): ……………………………………………

Address: ………………………………………………………………………………………………....................

Emergency contact Information; Telephone: ……………………………… Mobile: ………………………………

Relationship to you: ……………………………………………………………………………………………….....

PLEASE ASK NEXT OF KIN TO SIGN & DATE BELOW

I consent to my information above to be held on this patient's records

Sign: ……………………………….. Print: …………………………………….. Date: …………………..

2. Title: ……… Surname: ………………………………… Forename(s): ……………………………………………

Address: ………………………………………………………………………………………………....................

Emergency contact Information; Telephone: ……………………………… Mobile: ………………………………

Relationship to you: ……………………………………………………………………………………………….....

PLEASE ASK NEXT OF KIN TO SIGN & DATE BELOW

I consent to my information above to be held on this patient's records

Sign: ……………………………….. Print: …………………………………….. Date: …………………..

Marital/Relationship Status (Please circle)

Are you? Single / Married / Civil Partnership / Co-habiting / Divorced / Widowed

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Summary Care Record (SCR)

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

YES – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only

OR

☐ Express consent for medication, allergies and adverse reactions and additional information

NO – I wish to opt out of Summary Care Record

☐ Express dissent for Summary Care Record. Go to (www.nhs.uk/your-nhs-data-matters) and set a national data opt-out

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies orreactions to previous medication.)

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

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Local Shared Electronic Health Record

Many areas of the country have a local shared electronic health record too. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Are you happy for your record to be shared across organisations caring for you? (this is accessed by relevant staff for your direct care on a need-to-know basis only)

Are you happy to be part of the local shared electronic health care record?
(if you select no, you need to be aware that NHS Healthcare staff may
not be able to see important elements of your care history)

Yes ☐ **No** ☐

General Practice Data for Planning and Research Data Sharing

Register your Type 1 Opt-out preference

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: https://www.nhs.uk/your-nhs-data-matters/

You can use this part of the form to:

- register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
- withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

This decision will not affect individual care and you can change your choice at any time

Details of the patient

Title	
Forename(s)	
Surname	
Address	
Phone number	
Date of birth	
NHS Number (if known)	

Details of parent or legal guardian

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

Name	
Address	
Relationship to patient	

Your decision

☐ **Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes except their own care.

☐ **Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

Your declaration

I confirm that:

- the information I have given in this form is correct
- I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

Signature ☐

Date signed ☐

Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. As a practice, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……………………………………………………………………………………

Address……………………………………………………………………………………………………

Postcode…………………………………………………………………………………………………

Donor Wishes

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.
If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit:
https://ardens.live/Organ-donation-opt-out

Do you have a donor card or are you on the organ donation register? **Yes** ☐ **No** ☐

Have you opted out? **Yes** ☐ **No** ☐

Do you donate blood? **Yes** ☐ **No** ☐

Resuscitation Wishes and Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes** ☐ **No** ☐

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes** ☐ **No** ☐

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).
Details……………………………………………………………………………………………………

Height/Weight

What is your height: ……………………………………………………………………………………..

What is your weight:……………………………………………………………………………………..

If you would like advice on managing a healthy weight, please contact https://www.nhs.uk/live-well/ or reception who will be able to direct you to the most appropriate service.

Disabilities / Accessible Information Standards_

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs? **Yes** ☐ **No** ☐

If yes, please state your needs;…………………………………………………………………………….

Do you have significant mobility issues? **Yes** ☐ **No** ☐

If yes, are you housebound? **Yes** ☐ **No** ☐
(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

Transfusion History

Did you have a blood transfusion before 1991? **Yes** ☐ **No** ☐

Medications

Please provide a list of repeat medications: **PLEASE BRING A COPY OF YOUR REPEAT MEDICATION LIST FROM YOUR PREVIOUS GP.**

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……
……
……

Allergies

Please list any drug or food allergies that you have:

……
……
……