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| **PATIENT REGISTRATION FORM UNDER 16** |
| Today’s Date: |
| **PATIENT INFORMATION** |
| Surname: | Forenames: |
| Date of Birth: | Occupation: |
| Ethnic Origin: | Main Language: |
| Tel No. Home: | Tel. No. Mobile: |
| E-mail: |
| It’s important you provide your e-mail to get online access to your medical records. We will also keep you updated on our services.  |
| **IN CASE OF EMERGENCY** |
| Title: | Gender: |
| Full Name: | Relationship: |
| Address: | Contact number: |

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| Have you suffered from any of the following and if so, when? |
|  |  |  |  |  |  | Yes | No |  |  |  |  |  |  |  |  | Yes | No |  |  |
| High blood pressure | ❑ | ❑ | **…………..** | **Diabetes** | ❑ | ❑ | **…………..** |
| Heart Problems | ❑ | ❑ | **…………..** | **Stroke** | ❑ | ❑ | **…………..** |
| Asthma | ❑ | ❑ | **…………..** | **Bronchitis** | ❑ | ❑ | **…………..** |
| Eczema | ❑ | ❑ | **…………..** | **Hayfever** | ❑ | ❑ | **…………..** |
| Thyroid disease | ❑ | ❑ | **…………..** | **Glaucoma** | ❑ | ❑ | **…………..** |
| Tuberculosis | ❑ | ❑ | **…………..** |  |  |  |  |
| Other illnesses……………………………………………………………………… |

 Are you allergic to anything (especially any medication)? |
| Have you had any serious operations or injuries?  |
| Do you have any current health problems? |
| **PRESENT MEDICATION – Please bring repeat medication slips from previous doctor** |
| **Name of Medication** | **Dose** | **When started** |
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| **Would you like your repeat prescription to be sent directly to a chemist? Yes** ❑ No❑If the answer is yes, please provide chemist details you would like your prescription to be sent to: |
| **SUMMARY CARE RECORD – your emergency care summary** |
| Today, records are kept in all the places where you receive care.These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.We are introducing Summary Care Records to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when your GP practice is closed. We are telling you about this before a Summary Care Record is made for you, so that you have time to think about your choices.**You can choose to have a Summary Care Record:**You do not need to do anything. This will happen automatically. Healthcare staff will ask your permission every time they look at your Summary Care Record.**You can choose not to have a Summary Care Record:**If you don’t want a Summary Care Record, you need to let your GP practice know by filling in and returning an opt-out form. 1. ❑ **I do** want my records to be sent to other services
2. ❑ **I do NOT** want my records to be sent to other services
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| **CareMyWay RECORD** |
| What is CareMyWay? CareMyWay is a new Integrated Digital Care Record which means that for the first time, all of your health and social care data will be stored in one place. This will mean a faster, better service for you.Health and social care professionals can make better decisions about your care if they have up-to-date, more complete information available to them. The CareMyWay Integrated Digital Care Record will improve information sharing between the organisations providing health and social care services. This will mean that more time can be spent on care and better decisions can be made about your careYou can choose if you want a CareMyWay Integrated Digital Care Record. Your CareMyWay Integrated Digital care can only be seen by health and social care professioanls involved In your care, and only after you have given permission for them to look at it.1. ❑  **Yes** I would like a CareMyWay Integrated Digital care Record
2. ❑ **No**  I do not want a CareMyWay Integrated Digital care Record
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| **ONLINE ACCESS TO GP SERVICES** |
| If you wish to, you can now request repeat prescriptions for any medications you take regularly and look at medical records online on behalf of your child. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.**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.****I wish to have access to:**  |
| Requesting Repeat Prescriptions | 🞏 |
| Accessing my child’s medical records | 🞏 |
| **To access your medical records make sure you understand the following:** |  |
| I will be responsible for the security of the information I see or download | 🞏 |
| If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | 🞏 |

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you are filling out this form on behalf of another person or child, their GP practice will consider this request.**

**Please ensure you fill out the details bellow:**

|  |  |
| --- | --- |
| **Your name:** | **Your Signature:** |
| **Relationship to patient:** | **Date:** |