

Please complete in BLOCK CAPITALS and tick  as appropriate

## Patient's details

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 doctor while at that address \_\_\_\_\_

Address of previous doctor \_\_\_\_\_

## 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 \_\_\_\_\_

## If you are returning from the Armed Forces

Address before enlisting \_\_\_\_\_

Service or Personnel number \_\_\_\_\_ Enlistment date \_\_\_\_\_

## If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

## If you need your doctor to dispense medicines and appliances\*

- I live more than 1 mile in a straight line from the nearest chemist
- I would have serious difficulty in getting them from a chemist

*\*Not all doctors are authorised to dispense medicines*

Signature of Patient  Signature on behalf of patient Date: / /

### NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or
- Kidneys  Heart  Liver  Corneas  Lungs  Pancreas  Any part of my body

Signature confirming my agreement to organ/tissue donation \_\_\_\_\_ Date: / /

For more information, please ask at reception for an information leaflet or visit the website [www.uktransplant.org.uk](http://www.uktransplant.org.uk), or call 0300 123 23 23.

### 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

Signature confirming consent to inclusion on the NHS Blood Donor Register \_\_\_\_\_ Date: / /

For more information, please ask for the leaflet on joining the NHS Blood Donor Register  
My preferred address for donation is: (only if different from above, e.g. your place of work) \_\_\_\_\_  
Postcode: \_\_\_\_\_

HA use only Patient registered for  GMS  CHS  Dispensing  Rural Practice

## To be completed by the doctor

Doctors Name

HA Code

<input type="checkbox"/> I have accepted this patient for general medical services	<input type="checkbox"/> For the provision of contraceptive services
<input type="checkbox"/> I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice	

Doctors Name, if different from above

HA Code

<input type="checkbox"/> I am on the HA CHS list and will provide Child Health Surveillance to this patient or
<input type="checkbox"/> I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

<input type="checkbox"/> I will dispense medicines/appliances to this patient subject to Health Authority's Approval
<input type="checkbox"/> I am claiming rural practice payment for this patient.

**Distance in miles between my patient's home address and my main surgery is**  
 I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Practice Stamp

Authorised Signature

Name

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### SUPPLEMENTARY QUESTIONS

#### 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 EHC, 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:
Print name:	Relationship to patient:
On behalf of:	

Complete this section if you live in another EEA 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 EHC 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: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p>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.</p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	
	PRC validity period (a) From:	

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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.



# New Patient Registration Form

Please complete fully in BLOCK CAPITALS

## ABOUT YOU

Full Name: .....

Date of Birth: ..... Marital Status: .....

Address: .....

..... Post Code: .....

Telephone No: ..... Email Address: .....

Mobile No: ..... Are you happy for us to contact you by text/email? YES / NO

Ethnic Origin: ..... Do you require an Interpreter? YES / NO

First Language: ..... Next of Kin (name and Contact no) : .....

Have you ever served in the UK Forces? (if yes please specify) .....

Do you have any communication and/or information needs? (please specify)

Third Party Consent - I would like any information about my healthcare to be shared and discussed with the nominated person detailed below:

Full Name: ..... Date of Birth: .....

Relationship to you: .....

Please ensure that you contact the practice if this consent changes or you withdraw it so that we can update your records.

Are you a Carer? YES / NO (if yes please ask for our Carers registration form)

Name and relationship of the person you care for:

**MEDICATION** - Please note if you are on any current medications or have any health problems for which you see a Doctor regularly, please book in to see a Doctor for your new patient check.

Are you on any regular medication? YES / NO (if possible please attach a copy of your repeat slip from your previous surgery)

Please indicate your chosen pharmacy for your medication to be dispensed: .....

Do you have any drug/medicine allergies? YES / NO (if yes please state)

**You will automatically be signed up for our online services.  
Please ensure you have advised us of your email address.**

Continued overleaf

**PAST MEDICAL HISTORY** - Please list any serious illness or operations you have had in the past

**FAMILY HISTORY** - Please list any family history of illness including the family member and their age at diagnosis if Known. Especially Heart disease, strokes, diabetes, high cholesterol, cancers or asthma.

**YOUR HEALTH** – Please take a token from reception and use our Patient POD

Weight: ..... Height: ..... Blood Pressure .....

**Smoking Status**

Never Smoked	
Ex-Smoker (include date stopped)	
Smoker (how much?)	
Electronic Cigarette user	

**Alcohol**

	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

**WOMEN ONLY**

Have you had a Cervical Smear? YES / NO If YES the date of your last test .....

Have you had a Hysterectomy? YES / NO If YES the date of your operation .....

Do you use any Contraception? YES / NO If yes what do you use? .....

Signed ..... Date .....

If you are signing on behalf of someone else please state relationship to the patient: .....

**PLEASE ENSURE YOU KEEP US UP TO DATE WITH ANY CHANGES TO YOUR CONTACT DETAILS**





# SHARING YOUR NHS PATIENT DATA

Information sharing in the NHS is subject to rigorous regulation and governance to ensure your full identifiable and personal medical data is kept confidential and only ever seen by carefully vetted doctors, nurses and administrative staff responsible for overseeing your care.

With the development of information technology the NHS will increasingly be sharing key information from your GP medical notes with Out of Hours GP Services, Hospital A&E Units, Community Hospitals, Community Nurses all of whom may at various times in your life be looking after you. Sharing information can improve both the quality and safety of care you receive and in some cases can be vital in making life-saving decisions about your treatment.

There are currently two different elements of "sharing NHS patient information"

- **SCR = The NHS Summary Care Record**
- **EDSM = The Enhanced Data Sharing Model "SystemOne"**

We ask you please to read the information on this document carefully and complete the relevant fields on the attached form and return it to your GP surgery.

## SCR = NHS SUMMARY CARE RECORD

The NHS Summary Care Record was introduced many years ago to help deliver better and safer care; it contains basic information about:

- Any allergies you may have,
- Unexpected reactions to medications, and
- Any prescriptions you have recently received.

The intention of the SCR is to help clinicians in Hospital A&E Departments and GP 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians are only allowed to access your SCR record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record 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.

Over time, health professionals treating you may add details about any health problems and summaries of your care. Every time further information is added to your record, you will be asked if you agree (explicit consent).

Patients under 16 years have an NHS Summary Care Record created for them so 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.

## EDSM = ENHANCED DATA SHARING MODEL "SYSTEMONE"

The database and software used to store your GP health record is called "SystemOne" it is a very secure national system used by over 2000 GP practices and 4800 NHS organisations including GP out of hour's services, children's services, community services and some hospitals. Most GP Practices in the Northern locality use this same confidential clinical computer system. The system gives your GP the facility to share your record with other NHS health providers that use the same clinical computer system and are involved in your care for example the local Community Nurses who may look after you if you when you leave hospital or become terminally ill or housebound. Allowing your GP to share your record in the "SystemOne" database helps to deliver better and safer care for you. It is the policy of all local GP practices to automatically opt registered patients into "SystemOne" sharing unless they expressly decline. Those patients who choose to decline are able to determine if their data is "shared out" and/or "shared in"

**Sharing OUT** controls whether information recorded at our GP practice can be shared with other NHS health care providers.

**Sharing IN** determines whether or not our GP practice can view information in your record that has been entered by other NHS services who are providing care for you or who may provide care for you in the future (*that you have consented to share out*).

To Lyn Health Patient Services Team

## NHS PATIENT INFORMATION SHARING – MY CHOICES

Please complete the boxes below to detail your personal decisions regarding the aspects of NHS patient data sharing:

It is very important you sign this form to say that you understand and accept the risks to your personal health care if you do decide to opt out of SCR or EDSM. Hand the completed form in to your GP Surgery; they will scan this form into your NHS GP Medical Records and enter the appropriate information.

<b>GP Practice</b>	Lyn Health
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<b>Patients full NAME</b>	
<b>Patients DATE OF BIRTH</b>	

### 1. SCR - NHS SUMMARY CARE RECORD

Please tick only one box.

- Express consent for medication, allergies and adverse reactions only
- Express consent for medication, allergies, adverse reactions and additional info  
(recommended)
- Express dissent – Patient does not want a summary care record and fully understands the risks involved with this decision

### 2. EDSM – ENHANCED DATA SHARING MODEL “SystemOne”

**Sharing Out** – Do you consent to the sharing of data recorded by your GP practice with other NHS organisations that may care for you?

- YES share data with other NHS organisations (recommended)
- NO do NOT share any data recorded by my GP Practice; I fully accept the risks associated with this decision

**Sharing In** – Do you consent to your GP Practice viewing data that is recorded at other NHS organisations and care services that may care for you?

- Consent Given (recommended)
- Consent Refused; I fully accept the risks associated with this decision.

<b>Patient's full SIGNATURE</b>		<b>DATE</b>	
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