

Patient's details

Please complete in BLOCK CAPITALS and tick as appropriate

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 GP practice while at that address _____
 _____ Address of previous GP practice _____

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 _____

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: Regular Reservist Veteran Family Member (Spouse, Civil Partner, Service Child)
 Address before enlisting: _____
 _____ Postcode _____
 Service or Personnel number: _____ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)
Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

I live more than 1.6km in a straight line from the nearest chemist
 I would have serious difficulty in getting them from a chemist
 Signature of Patient Signature on behalf of patient
 _____ Date ____/____/____

**Not all doctors are authorised to dispense medicines*

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

Signature confirming my consent to join the NHS Organ Donor Register Date ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register Date ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: _____

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for GMS Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

 I have accepted this patient for general medical services on behalf of the practice

 I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name

Date ____/____/____

Practice Stamp

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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 EHIC, 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:	DD MM YY
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 EHIC 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><i>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.</i></p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

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 – Child

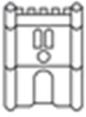
Thank you for choosing to register with The Guildhall & Barrow Surgery.

Please fully complete this questionnaire about your child, writing clearly and in **BLOCK CAPITALS**. If you require any assistance, please speak to Reception.

We ask that you bring your child's birth certificate or red book, and **your** photographic ID when registering **if these documents are available**.

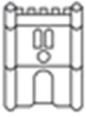
If you do not have these documents, you are still able to register your child with our Practice.

Full Name:		Date of Birth:	
		Gender:	
Address:			
Postcode:			
Home Phone Number:	Parent's Mobile Number:	Child's Mobile Number:	
Email Address:			
Consent to contact via email: Yes <input type="checkbox"/> No <input type="checkbox"/>		Consent to contact via text message: Yes <input type="checkbox"/> No <input type="checkbox"/>	
NHS Number:		Place of Birth:	
		Birth Weight:	
Current Height:		Current Weight:	
Ethnicity:			
Main spoken language:		Translator required? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the child have any communication, or building access needs? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, please provide details to reception
Is the child a carer? Yes <input type="checkbox"/> No <input type="checkbox"/>		If the child spends time looking after a relative, parent, sibling or friend who is disabled or has a mental health difficulty, they are a carer	
If yes, who does the child care for?			
Would you like to hear from other organisations that can support young carers?		Yes <input type="checkbox"/>	No <input type="checkbox"/>



THE GUILDHALL & BARROW SURGERY

Name of Parent/Guardian registering the child:	
Mother's Full Name:	Mother's Previous Name (if applicable):
Mother living at the same address? If No, please provide address:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mother registered at this surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Father's Full Name:	Father's Previous Name (if applicable):
Father living at the same address? If No, please provide address:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Father registered at this surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Who is the PRIMARY carer? If other, please give details:	Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/>
Who has parental responsibility? If other, please give details:	Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/>
Name and Address of current School/Nursery/Childminder(if applicable):	
Do you have a family social worker?: If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the child been subject to a Child Protection Plan? If yes, please provide details:	Yes <input type="checkbox"/> No <input type="checkbox"/>



THE GUILDHALL & BARROW SURGERY

Please list the names of other household members living within the household i.e siblings, relatives, friends.

Name	Relationship

Does the child have siblings not living with them? Yes No

If yes, please give details:

Next of Kin Name and Address:	Relationship to the child:
	Contact Telephone Number:

Vaccination Records

Please complete the following immunisation details, using the data from your child's red health book

Age Due	Vaccine	Tick if given	Date Given
8 weeks	1st DTa/IPV/Hib	<input type="checkbox"/>	
	1st Pneumococcal (PCV)	<input type="checkbox"/>	
	1st MenB	<input type="checkbox"/>	
	1st Rotavirus	<input type="checkbox"/>	
	1st Hep B if born after 1st Sep 2017	<input type="checkbox"/>	
12 weeks	2nd DTa/IPV/Hib	<input type="checkbox"/>	
	2nd Rotavirus	<input type="checkbox"/>	
16 weeks	3rd Dta/IPV/Hib	<input type="checkbox"/>	
	2nd MenB	<input type="checkbox"/>	
	2nd Pneumococcal (PCV)	<input type="checkbox"/>	
12 months	Hib and MenC	<input type="checkbox"/>	
	3rd Pneumococcal (PCV)	<input type="checkbox"/>	
	1st MMR	<input type="checkbox"/>	
	3rd MenB	<input type="checkbox"/>	
2 to 8 years	Influenza	<input type="checkbox"/>	
3 years, 4 months	DTa/IPV Booster	<input type="checkbox"/>	
	2nd MMR	<input type="checkbox"/>	
Girls aged 12-13	HPV (two doses given 6-24 months apart)	<input type="checkbox"/>	
14 years	Td/IPV	<input type="checkbox"/>	
	MenACWY	<input type="checkbox"/>	

Have you refused any of the vaccinations listed above? If so, which ones?



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MEDICAL HISTORY

Please list any serious illnesses, operations, accidents etc.

Month/Year

Is the child currently taking any medicines? Yes

No

If yes, please give details below:

Name of medicine

How often taken

Date started

Name of medicine	How often taken	Date started

Please indicate your nominated pharmacy for electronic prescriptions:

Address / location:

Please list any allergies your child has:

Family History - Please tick if a close relative has suffered from any of the following conditions and indicate their relationship to the child

Diabetes

Stroke

Asthma

Epilepsy

Heart Disease under 60

Cancer (please state type)

High Blood Pressure

Any other significant history

Online Services Registration

Reception can provide you with a username and password to enable you to book and cancel appointments, order medication and view a summary of your child's medical record, until the age of 14. Should you wish to make use of this convenient service, please provide some photographic ID to reception.

Yes, I am interested in using the online services (please tick the 'Yes' box)

Yes

Consent To Hold Your Records

The Practice needs to hold your medical records on the premises in order to give you the best medical care possible. We keep your records on the computer as well as holding paper notes. All of our patient's notes are covered by the Data Protection Act 1998. This means that a third party cannot access your records without your consent.

Summary Care Record

Your Summary Care record is an electronic record of important information about your health and is available to healthcare staff providing your NHS care in England, for example A&E. This means that if you ever become ill and need urgent or out of hours treatment outside of the surgery, the clinicians that treat you will have immediate access to important healthcare information about you. **If you do not want this to happen, please ask reception for an Opt-Out form**

Signature :

Date:

Relationship to the patient, if signing on their behalf:

Thank you for completing this form

For more information about the services we offer, please refer to the leaflets provided by reception or see our website: www.theguildhallsurgery.co.uk

Who can see my health record?

To treat you safely and well, it is important that professionals you see can access your health record.

Only by letting your GP surgery know it is ok will your notes be available to be seen by other professionals such as hospital clinicians, paramedics or district nurses.

How do I make my record available to health professionals?

Simple. Complete this form and hand it into your GP surgery. There are two ways that this sharing can happen and it's important you understand what they are so you can make the right decision for you.

A. Summary Care Record with Additional Information	
A Summary Care Record has basic information on that is useful for NHS clinicians. It shows if you have allergies and it lists your medications. 98% of people have this. By including "Additional Information", this will add your illnesses and any health problems, vaccinations, operations and information on how you would like to be treated.	

B. Full Electronic Health Record	
Your full electronic health record is held by your GP surgery. It can also be made available to health and social care staff, if they are involved in your direct care. Staff must still ask for your permission before they look at your record. This also allows your surgery to see what other staff are doing to support and treat you. If there are certain parts of your record that you wish to keep private, your surgery can do this.	

Does this mean anyone can just look at my record?

No. Your record can only be seen by staff who **are currently involved in your direct care, have a need to see it, and have asked for your permission.** The only exception to this is in case of an emergency. For instance, if you were taken to hospital unconscious, a doctor could look at your record without your permission. If this happens, a permanent alert is created showing who looked at the record and why.

Are you going to sell the information in my record?

Never. If your record is shared, it's only ever available to staff for the purposes of your care, nothing else.

Can I change my mind?

Yes. Just tell your surgery and they can update your decision at any time.

Your decision to agree to either one, or both

A	Yes, I am happy for additional information to be added to my Summary Care Record, this means healthcare staff treating me can see a summary of my medical history in addition to my medication and allergies*.		Please Tick
B	Yes, I am happy for my full health record to be shared by my GP surgery. This will be available to health and social care professionals who are currently treating me, and have my permission to view it.		

**If you already have a basic summary care record and now wish to opt out of this completely, please ask your practice for an SCR consent form.*

Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

If you are filling in this form on behalf of another person, please ensure that you fill in their details above; you sign the form above and provide your details below:

Name: _____ Parent Legal Guardian Lasting power of attorney

For more information about the Summary Care Record and health record sharing, please refer to www.bit.ly/whocanseemyrecord or call PALS on 0800 389 6819.

Information for GP Practices	
A	To opt patient in to SCR with Additional Information, add read code XaXbZ (SystemOne) or 9Ndn (EMIS)
B	For health record sharing: In SystemOne, choose " Record Sharing " and then " Yes " and " Consent given ". In EMIS Web, choose " Sharing " from the Care History tab, " EMIS Sharing Consent " and choose " Patient Consents ".