Lisson Grove and Woolwell Medical Centre **Appendix 1**

Registration form for SystmOnline

Please kindly submit this form in person along with your Photographic ID and separate proof of address.

You may request access to SystmOnline for your children under the age of 15 that are living with you at your registered home address. Please list any children that you would like access for OVER THE PAGE.

To ensure confidentiality we are only able to accept registrations in person – i.e. **you cannot give your details to anyone else to register for you.**

Surname	Date of birth
First name	
Address Postcode	
Email address (Print Clearly):	
Telephone number	Mobile number

Prescriptions requested via SystmOnline will be sent electronically to your nominated pharmacy. Please state your nominated Pharmacy here: ____

A combination of the following can be accepted as identification. At least one MUST be a photo ID, along with one document containing your address:

One of the Following Photo ID: Photo card Driving Licence, Passport, Bus Pass

One of the Following Proof of Address: Local authority rent card, Paid Utility bills, Bank/Building Society Statement, Pay slip, P60, Papers from a government department, Letter from benefit agency, House or motor insurance certificate, Tenancy Agreement

The following documents WILL NOT be accepted as proof of identity: Library card, Video rental card, Health club card, Private rent card, Birth Certificate (Adult patient)

Patient Consent

I consent to the practice providing me with the online facility to book/cancel appointments, order repeat prescriptions and view my online medical record* through SystmOnline. I consent to the Practice contacting me using email and sms text messaging. It is my responsibility to keep my account secure by keeping my log in details confidential. I understand that I can terminate my account at any time by contacting the surgery, or change my log in details by re-registering, and that this form will be kept on my electronic records. I would use this service responsibly and in the case of any abuse of the service, Lisson Grove & Woolwell Medical Centre can prevent me from accessing the service by stopping the username and password from working.

Examples of irresponsible use of the system may include, but are not limited to:
Registering at a GP practice outside your catchment area, booking appointments you have no intention of attending, repeatedly booking and then cancelling appointments, repeatedly requesting prescriptions that you do not need.
The practice is committed to protecting my privacy online. The personal information I enter on this website is strictly controlled. Information entered is available only to members of staff with appropriate access rights at Lisson Grove & Woolwell Medical Centre - i.e. those managing appointment booking, repeat prescribing and patient registration. Patient's personal information will not be shared with any third parties. Patient's personal information will not be sold to any third parties.

**Your online medical record will include your Summary Care Record (SCR), unless you have previously opted out of having a SCR, your Medications and Vaccinations and your Detailed Coded Record (this includes anything which has been flagged electronically and is a confirmed diagnosis or condition). If you feel something is missing from your electronic record then please advise us a soon as possible.*

Patient signature:	Date:

Child 1 full name: ______________________________

Child 1 Date of Birth: ______________________________

Proof of parental responsibility required
(full birth certificate)

Confirmed by staff ☐
Staff Initials: __________
Address and relationship confirmed as registered user on page one ☐

Child 2 full name: ______________________________

Child 2 Date of Birth: ______________________________

Proof of parental responsibility required
(full birth certificate)

Confirmed by staff ☐
Staff Initials: __________
Address and relationship confirmed as registered user on page one ☐

Child 3 full name: ______________________________

Child 3 Date of Birth: ______________________________

Proof of parental responsibility required
(full birth certificate)

Confirmed by staff ☐
Staff Initials: __________
Address and relationship confirmed as registered user on page one ☐

Surgery staff to complete:

<table>
<tr><td>Identity verified by:
(staff initials)</td><td>Date</td><td colspan="2">Method:
Vouching ☐
Vouching with information in record ☐
Photo ID and proof of residence ☐</td></tr>
<tr><td colspan="4">Details of ID Verification Documents / Notes / Confirmation of Vouch:
Photo ID:
Proof of Address:
Vouch details:</td></tr>
<tr><td colspan="3">Authorised by</td><td>Date</td></tr>
</table>

ID Confirmed ☐
Instructions & Login given ☐
Details updated on SystmOne ☐
Completed document scanned onto patient records ☐