Partners: Drs R G Crispin & C Carrigan

The Clanfield Practice

2 White Dirt Lane Clanfield Waterlooville Hampshire PO8 0QL
Telephone: 023 9259 3285
Facsimile: 023 9259 5855
Website: www.theclanfieldpractice.nhs.uk
Email: SEHCCG.ClanfieldSurgery@nhs.net

Your registered Dr is ………………………………………………………………………………….

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

If yes: ☐ Sign Language ☐ Large Print ☐ Other
…………………………………………………………………

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth day/month/year NHS No ☐☐☐ ☐☐☐ ☐☐☐☐

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Where did you last receive treatment? Date:

ie GP, Walk in Centre, MIU, Emergency Department etc

What was the outcome of this visit? ie prescription

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No

If yes and the person you care for is registered at this surgery please provide their details:

Do you have a carer? ☐ Yes ☐ No

Are you happy for us to contact your carer about you? ☐ Yes ☐ No

If yes, please tell us the name & address of your Carer:

For patients aged 65 or over: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities?
☐ Yes ☐ No

In general, do you have any health problems that require you to stay at home?
☐ Yes ☐ No

Do you regularly use a stick, walker or wheelchair to get about?
☐ Yes ☐ No

In case of need, can you count on someone close to you?
☐ Yes ☐ No

Do you need someone to help you on a regular basis?
☐ Yes ☐ No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate **who** in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Immunsation	**Year**	**Immunisation**	**Year**
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No

If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐ Pipe

Are you an ex-smoker? ☐ Yes ☐ No

When did you give up?

How many cigarettes/ cigars do you smoke daily?

☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week?

Would you like help to quit smoking?
☐ Yes ☐ No

Lifestyle exercise ……

Do you exercise: ☐ Yes ☐ No

If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

Female patients only ……

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No If yes, how many? [ ]

Which method of contraception (if any) are you using at present? [ ]

Have you had a cervical smear test? ☐ Yes ☐ No If yes, what was the result? (if known) [ ]
Date (if known) [ ]

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state): [ ]
☐ Decline to state

Next of kin ……

Name: [ ] Tel. contact number: [ ]

Relationship: [ ]

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for The Clanfield Practice to contact you by the following:

By email	☐ Yes	☐ No	This will be to send you letters, newsletter and the like
By text	☐ Yes	☐ No	This will be to send you reminders of appointments via text

Signature ……

I confirm that the information I have provided is true to the best of my knowledge.

Signed: ______________________ Date: __________

Signature of patient ☐ Signature on behalf of patient ☐

Updated 21/1/2020

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South Eastern Hampshire
Clinical Commissioning Group

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CARE AND HEALTH INFORMATION EXCHANGE PATIENT CONSENT FORM

Check the following details are correct and amend or complete as necessary:

Please Tick: **Dr** ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐

First Name(s): (in full) ____________________

Last Name: ____________________

Home Address: ____________________

Date of Birth: ____________________

Declaration: To be completed by the applicant. Please note that any attempt to mislead may result in prosecution.
I………………………………………………………………. Certify that the information given on this application form is true. I understand that it is necessary for the Care and Health Information Exchange to confirm my identity, and that it may be necessary to make further checks in order to ensure the correct information is provided.

Please tick JUST one of the boxes below to indicate your required preference

☐ I wish to opt into sharing my data to both the Care and Health Information exchange (CHIE) and Care and Health Analytics (CHIA)

☐ I wish to opt out of sharing my data to the Care and Health Information Exchange (CHIE) **and/or** Care and Health Analytics (CHIA) ***please delete as applicable***

……………………………………………………… ……………………………..
Signature of Patient **Date**

NHS Digital

Information for new patients: about your Summary Care Record

Dear patient,
If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice. You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

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

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ……………………………………………..….......................

Date of birth: …………………………… Patient's postcode: …………………

Surgery name: …………………………… Surgery location (Town): ………........................

NHS number (if known): ………………………..………………..................................

Signature: ……………………………. Date: ………………………………

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

Name: ………...…................

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only
To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6

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