Roslea Surgery

Complete this form in addition to GMS1
Please complete all sections by writing clearly or by ticking the relevant boxes.

Name	
Home Telephone No	
Mobile Telephone No	
e-mail – will be needed for online access)	
Next of Kin (NOK)	Name: …….. Address: …….. Tel: …….. Relationship:…… Do you consent for us to contact your NOK in the event of an emergency? Yes ☐ No ☐

Ethnicity		
White ☐White British ☐White Irish ☐White Other *Black/Black British* ☐Black Caribbean ☐Black African ☐Black other	*Asian/Asian British* ☐Asian Indian ☐Asian Pakistani ☐Asian Bangladeshi ☐Asian Other *Chinese/Chinese British* ☐Chinese	*Mixed* ☐White & Black Caribbean ☐White & Black African ☐White & Asian ☐Other Mixed *Other* ☐Other Ethnic Group *Decline* ☐Decline to say

Communication Needs

What is your First Language?.....Do you require an interpreter? Yes ☐ No ☐

Do You have a **Sensory Visual Hearing** Impairment? (Please circle)

Do you have Learning Disabilities? Yes ☐ No ☐

Any significant health problems?
Problems we need to know about include Heart Disease, Cancer, Asthma, Diabetes or Mental Health

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Repeat Medication

Are you on any regular repeat Medication? Yes ☐ No ☐
If you take medication regularly (including contraception, tablets, cream and inhalers) please give the right side or print out of your prescription to reception, ticking any items you require. Please bring your medication with you when you attend an appointment with the clinician.

Lifestyle Information

Height:…… □ Metres □ Feet and Inches

Weight:……. □ Kilograms □ Stones and Pounds

Smoking Status □ I have never smoked	□I am a current smoker, and smoke: □less than 1 per day □1 to 9 per day □10 to 19 per day □20 to 39 per day □More than 40 per day	□I am an ex-smoker and used to smoke: □less than 1 per day □1 to 9 per day □10 to 19 per day □20 to 39 per day □More than 40 per day Date stopped:

Any Allergies or Reactions? (eg to: medicines, vaccinations, medical dressings, foodstuffs or eggs)

FAMILY HEALTH HISTORY
All questions are strictly confidential and will become part of your medical record

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Sibling M F		
Mother			Sibling M F		
Child M F			Sibling M F		
Child M F			Maternal Grandmother		
Child M F			Maternal Grandfather		
Child M F			Paternal Grandmother		
Child M F			Paternal Grandfather		

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Alcohol Consumption

Units of alcohol consumed per week:

1. How often do you have 8 (men) 6 (women) or more standard drinks on one occasion?
   - **Never**
   - **Less than monthly**
   - **Monthly**
   - **Weekly**
   - **Daily/ almost daily**

2. How often in the last year have you not been able to remember what happened when drinking the night before?
   - **Never**
   - **Less than monthly**
   - **Monthly**
   - **Weekly**
   - **Daily/ almost daily**

3. How often in the last year have you failed to do what was expected of you because of drinking?
   - **Never**
   - **Less than monthly**
   - **Monthly**
   - **Weekly**
   - **Daily/ almost daily**

4. Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advise you to cut down?
   - **No**
   - **Yes, but not in the last year**
   - **Yes, during the last year**

Exercise

Please circle the tick n which applies to you

✓ Physical exercise impossible

✓ Exercise level limited

✓ Enjoys light exercise

✓ Enjoys moderate exercise

✓ Enjoys heavy exercise

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Carers
A carer could be a family member or a paid carer.

Do you have a carer? Yes ☐ No ☐

Name of carer……..contact number……..

Relationship…… Is this person your main carer Yes ☐ No ☐

Is the carer your next of kin? Yes ☐ No ☐

Can we contact your carer in an emergency Yes ☐ No ☐

Do you consent to the carer having access to your clinical record Yes ☐ No ☐
If **YES please ask reception for a consent form from reception**

Are you a carer for anyone else including family member or friend? Yes ☐ No ☐

If you are a carer please complete a Carers' pack which can be obtained from reception.

Children Under the age of 18

Do you have a Social Worker? Yes ☐ No ☐

Are you a looked after child? Yes ☐ No ☐

The Deprivation of Liberty Safeguards (DoLs)

The Deprivation of Liberty Safeguards (DoLs) are part of the mental capacity act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Is there a DoLs in place for the person registering Yes ☐ No ☐
If yes please provide details

DNACPR (Do not attempt resuscitation)

Do you have a DNACPR (Do not attempt resuscitation) in place Yes ☐ No ☐

If yes where do you keep the form? …….

Other Information

Are you an Asylum Seeker? Yes ☐ No ☐

Are you homeless? Yes ☐ No ☐

Are you a Military Veteran? Yes ☐ No ☐

Have you appointed a Power of Attorney for Health and Wellbeing Yes ☐ No ☐
(original document to be brought into surgery to be scanned into your medical record)

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Patient Care Text Messaging Consent Form

Declaration
I consent to the practice contacting me by text message for the purposes of

Health appointment reminders ☐ Health Promotion ☐ Test results ☐

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

The surgery does not offer a reply facility to enable the patient to respond to texts directly.

Text messages are generated using a secure facility however I understand they are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Mobile number ……

Patient Name ……

Patient Signature …….. Date ……
The practice does not share mobile phone contact details with any external organisation.

EMIS Access Online/My GP APP

This facility is currently available for routine doctor's appointments and repeat prescriptions.
All booked appointments are cancellable on-line; if an appointment booked is NOT cancelled without good reason, and results in a "did not attend" the surgery reserves the right to revoke its use.

Confidentiality and Security

Information sent via EMIS Access is encrypted so messages sent cannot be intercepted or read by others, only the patient and the practice are able to see any personal information.
The computer system is connected to EMIS Access through the NHS network. The surgery will only enable the internet access facilities if requested to do so by the patient.

Terms and Conditions

Whilst the surgery makes all reasonable efforts to provide the service, it is not liable for any failure to provide the service, in part or full, for any cause that is beyond its reasonable control. This includes any suspension of the service resulting in maintenance and upgrades to the system or those of any party used to provide the service.

You must keep your personal details secret and take all reasonable precautions to prevent fraudulent use of your personal details. If fraudulent use is suspected, contact the surgery as soon as possible.

The Surgery reserves the right to change the service from time to time and shall give appropriate notice of any material changes. They may, where considered appropriate for patient protection suspend, withdraw or restrict the use of the service. Patients will be notified as soon as practicable if any such action is taken. The surgery reserves the right to vary these terms and conditions and appropriate notice will be given of any material changes.

Application for an EMIS Access Account
I would like to apply for an EMIS Access Account which gives me the ability to book routine GP

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appointments, cancel my appointments and request my repeat medication over the internet.

Please Tick

☐ I prefer my account details to be emailed to the address I have given above.

☐ I will collect the letter containing my account details from reception in person.

☐ I would like to nominate a friend/relative/carer to collect my account details on my behalf. I understand the person collecting my details will have access to my confidential account information and I take full responsibility for any misuse of my account or breaches of confidentiality that may occur as a result.

I have read and agreed with all the terms and conditions of use.

Signed: ……

Print Name:…..……...…. Date: ……..

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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.

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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.