Middleton and Dinsdale Medical Practice

New patient registration form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STAFF SIGNATURE |  | THE PATIENT ON MEDICATION | YES | NO |
| PATIENT I.D CONFIRMED |  | COPY OF MEDICATION LIST | YES | NO |
| NOMINATED PHARMACY |  | IS PATIENT IN A CARE HOME | YES | NO |

|  |
| --- |
| **PERSONAL DETAILS**  NAME: DOB:  ADDRESS:  TELEPHONE NUMBER: EMAIL ADDRESS: |
| **NEXT OF KIN:**  NAME: RELATIONSHIP TO YOU:  TELEPHONE NUMBER: |
| **ETHNIC ORIGIN:**  WHITE BRITISH WHITE OTHER BLACK AFRICAN BANGLADESHI BLACK CARIBBEAN VIETNAMESE CHINESE PAKISTANI  OTHER – PLEASE SPECIFY |
| **HEIGHT: WEIGHT:** |
| **SMOKING STATUS:**  NEVER SMOKED EX-SMOKER CURRENT SMOKER (please state amount per day) |
| **DETAILS OF ANY ALLERGIES:** |
| **ARE YOU A CARER?**  YES NO  IF YES:  NAME OF PERSON YOU CARE FOR: RELATIONSHIP TO YOU:  **PLEASE STATE HERE ANY COMMUNICATION CONSIDERATIONS YOU WOULD LIKE TO MAKE US AWARE OF:**  BLIND LEARNING DISABILITY  PARITALLY SIGHTED OTHER, PLEASE SPECIFY  DEAF |
| **ARE YOU CURRENTLY TAKING ANY MEDICATION?**  YES ( IF YES YOU WILL NEED TO PROVIDE YOUR REPEAT REQUEST SLIP OR MAKE AN APPOINTMENT TO SEE A GP)  NO  **NOMINATED PHARMACY:** |

**ALCOHOL QUESTIONNAIRE**

THIS FORM TO BE RETURNED WITH REGISTRATION DOCUMENTS

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| QUESTIONS | SCORE 0 | SCORE  1 | SCORE  2 | SCORE  3 | SCORE  4 | YOUR  SCORE |
| HOW OFTEN DO YOU HAVE A DRINK THAT CONTAINS ALCOHOL? | NEVER | MONTHLY OR LESS | 2-4 TIMES PER MONTH | 2-4 TIMES PER WEEK | 4+ TIMES PER WEEK |  |
| HOW MANY STANDARD ALCOHOLIC DRINKS DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING? | 1-2 | 3-4 | 5-6 | 7-8 | 10+ |  |
| HOW OFTEN DO YOU HAVE 6 OR MORE STANARD DRINKS ON ONE OCCASION? | NEVER | LESS THAN MONTLY | MONTHLY | WEEKLY | DAILY OR ALMOST DAILY |  |

**APPLICATION TO ACCESS TO GP ONLINE SERVICES – THINGS TO CONSIDER**

Total

Before you apply for online access to your medical health record, there are some things to consider.

**Forgotten History**

There may be something you have forgotten about in your record that you might find upsetting.

**Abnormal results or bad news**

If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

**Choosing to share your information with someone**

Its up to you whether you share your information with others or not – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

**Coercion**

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

**Misunderstood information**

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

**Information about someone else**

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

**More information**

For more information about keeping your healthcare records safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British computer society:  
Keeping your online health and social care records safe and secure

<https://www.nhs.uk/nhsengland/thenhs/records/healthrecords/documents/patientguidancebooklet.pdf>

**Proxy access**

If you are using this service to access another person's account as a proxy ( eg as a carer or parent),you have discussed appropriately what you are accessing and for what purpose. This service will be reviewed at regular intervals by the GP practice and may be rescinded at any time.

**APPLICATION FORM FOR ONLINE ACCESS TO THE PRACTICE ONLINE SERVICES**

|  |  |
| --- | --- |
| NAME:  DATE OF BIRTH: | |
| CONTACT NUMBERS: | |
| EMAIL ADDRESS: | |
| I wish to have access to the following online services ( Please tick all that apply ) | |
| 1 Booking appointments |  |
| 2 Requesting repeat prescriptions |  |
| 3 Accessing my online medical records ( please read statements below) |  |
| I Wish to access my online medical record and understand and agree with each statement (please tick) |  |
| I have read and understood the 'things to consider' leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, that it is at my own risk. |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible. |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the surgery As soon as possible. |  |
| If I think that I may come under pressure to give access to someone else unwillingly I will Contact the surgery as soon as possible. |  |
| Signature : | Date : |