

Birchwood Surgery

Additional Medical & Personal Information Pack

(This is not your Registration Form.
Please see inside for further details)

Adult



Welcome to Birchwood Surgery

Thank you for choosing us to be your family Doctor

What you need to do next :

1. Be aware that all patients must also fill out the GMS-1 form which can also be found on our website
2. Please obtain your NHS number from your previous GP practice if this is applicable before attending your registration appointment.
3. Contact the surgery to book in a registration appointment. (This is not currently required due to the Covid-19 Pandemic)
4. Complete all forms as thoroughly as possible and if possible attach a copy of your repeat prescription side slip if this is applicable.
5. Bring the completed forms and the required two (2) pieces of evidence (see list below) back to the surgery reception team.

Check List for proof of ID

Photo ID X 1	Proof of Address X 1
Passport <input type="checkbox"/>	Tenancy/Mortgage Agreement <input type="checkbox"/>
Driving Licence <input type="checkbox"/>	Bank Statement <input type="checkbox"/>
College/University Student Card <input type="checkbox"/>	Utility Bill under 3 months old Not Mobile phone bill <input type="checkbox"/>

BIRCHWOOD SURGERY

Privacy Notice

We understand how important it is to keep your personal information safe and secure. We have taken steps to make sure your personal information is looked after in the best possible way, and regularly reviewed.

If you would like to know how we use the personal and healthcare information we collect on your behalf, our Privacy Notice can be found on our website or alternatively you can request a copy from main reception.

Date:

- [illegible]

4	Your Religion (Please tick)	Church Of England <input type="checkbox"/>	Catholic <input type="checkbox"/>	Other Christian (state): <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Hindu <input type="checkbox"/>	Muslim <input type="checkbox"/>
		Sikh <input type="checkbox"/>	Jewish <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>	No religion <input type="checkbox"/>	Other religion (state) <input type="checkbox"/>	
	Your Ethnic Origin (Please tick one)	White (UK) <input type="checkbox"/>		White (Irish) <input type="checkbox"/>	White (Other) <input type="checkbox"/>		
	Black Caribbean / British <input type="checkbox"/>	Indian / British Indian <input type="checkbox"/>		Arabic <input type="checkbox"/>	Other Mixed Background <input type="checkbox"/>		
	Black African / British <input type="checkbox"/>	Pakistani / British Pakistani <input type="checkbox"/>		Chinese <input type="checkbox"/>	Other Asian Background <input type="checkbox"/>		
	Other Black Background <input type="checkbox"/>	Bangladeshi / British Bangladeshi <input type="checkbox"/>		Other <input type="checkbox"/>	Ethnic Category Refused <input type="checkbox"/>		
What is your main spoken language? Please Specify: Do you speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>				Do you need an Interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you need help with mobility/hearing/speaking? (tick all that apply)							
Wheelchair <input type="checkbox"/>	Walking aid <input type="checkbox"/>	Hearing aid <input type="checkbox"/>	British sign language (BSL) <input type="checkbox"/>		Makaton sign language <input type="checkbox"/>		
Lip reading: <input type="checkbox"/>	Large print: <input type="checkbox"/>	Braille <input type="checkbox"/>	Other. Please state: <input type="checkbox"/>				
Are you currently?	Homeless <input type="checkbox"/>	A Refugee <input type="checkbox"/>	An Asylum Seeker <input type="checkbox"/>				
Are you housebound?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Comments:				

Page 4

5	Lifestyle						
	Are you currently a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?				
	Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>						
	Alcohol:	Scoring System					Your Score
		0	1	2	3	4	
	How often do you have a drink containing alcohol?	Never	Weekly	2-4 Times Per week	Once a Day	4+ Times Per Day	
How many units* of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+		
How often have you had 6 or more units if female, or 8+ if male, on a single occasion in the last year?	Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily		
*Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units. 1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit		Total Score					

6	Diet and Exercise		What type of diet do you have?
	How much exercise do you do?		<input type="checkbox"/> Healthy
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate
	Please enter your height in		Please enter your weight in
Metres/Centimetres:		Kilos/grams:	

7	Females Only			
	What is the date of your last Smear test?		Date:	Result: if known
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Mammogram (if applicable):	
	Are you eligible for a cervical smear test?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If unsure please visit Cervical screening - NHS (www.nhs.uk) for guidance

8	Your Medical Background			
Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply and state family member:				
<input type="checkbox"/> Diabetes Who:		<input type="checkbox"/> Asthma Who:		<input type="checkbox"/> Thyroid disorder Who:
<input type="checkbox"/> Stroke Who:		<input type="checkbox"/> COPD Who:		
<input type="checkbox"/> Heart Attack under age of 60 Who:		<input type="checkbox"/> Cancer (Specify type) Who:		<input type="checkbox"/> High Blood pressure Who:
		Any other important family illness. Please state: Who:		
Please state any allergies and sensitivities you have to medicines, food & dressings:				
Please state any mental disabilities you have:				
Are you able to administer your own medicines?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If no please give details, e.g. swallowing or opening containers:
What long term medical conditions have you / do you have?				Date of Diagnosis:
1.				
2.				
3.				
4.				
What operations or serious injuries have you had?				Date of operations or injuries:
Please list any tablets, medicines or other treatments you are currently taking / undertaking:				
Name	Dose	Quantity/ How often	GP Prescribed?	
1.			Yes/No	
2.			Yes/No	
3.			Yes/No	
4.			Yes/No	
5.			Yes/No	
6.			Yes/No	
7.			Yes/No	
8.			Yes/No	
9.			Yes/No	
10.			Yes/No	

9	Patient Participation Group (PPG) The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved in the PPG, please visit the link on our website for further information and submit your interest. Alternatively if you do not have access to the internet and would like us to send the literature and application form out to you please tick the box below	
Yes I am interested in becoming involved in the PPG, please send out the relevant literature and application form. <input type="checkbox"/>		
No I am not interested in becoming involved in the PPG <input type="checkbox"/>		

10	Online Services & access to your medical records	
	<p>You can now do the following online or via the SystmOnline app:</p> <ul style="list-style-type: none"> ▪ Book and cancel appointments, ▪ order repeat prescriptions, ▪ View a summary of your medical record. ▪ Medical coded record <ul style="list-style-type: none"> ▪ IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. ▪ IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY. 	
	<p>Please Provide your Email Address:</p>	
<p>You will automatically be Opted in for online services, if you do not wish to be opted in for these services please tick the box to opt out.</p> <p>I wish to Opt out of online services <input type="checkbox"/></p>		

11	Electronic Prescription Service	
	<p>The Electronic Prescription Service (EPS) sends electronic prescriptions from GP surgeries to pharmacies. Eventually EPS will remove the need for most paper prescriptions. Please add your nominated pharmacy below. We will automatically send your prescriptions to your nominated pharmacy where possible.</p> <p>Nominated Pharmacy.....</p> <p>Once you have selected a pharmacy, please ensure you advise the pharmacy that you have selected them to receive and request your repeat medications.</p>	

12	Other Information		
	Do you have a "Living Will"? (A statement explaining what medical treatment you would not want in the future)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", can you please bring a written copy of it to your first appointment?
	Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", please state their Name: Address: Phone number:	
	Do you wish to be or are you a NHS Registered Blood Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wish to be or are you an NHS Registered Organ Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If you wish to be on the NHS Organ Donor Register please specify below which organs/tissue you would like to donate. Please tick the boxes that apply: <input type="checkbox"/> Any of my organs and tissue or <input type="checkbox"/> Kidneys <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Corneas <input type="checkbox"/> Lungs <input type="checkbox"/> Pancreas <input type="checkbox"/> Any part of my body		

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

You are free to change your decision at any time by informing your GP practice.

13	Summary Care Record Consent					
	Having read the above information regarding your choices, please choose one of the options below					
	Yes – I would like a Summary Care Record <input type="checkbox"/> Express consent for medication, allergies and adverse reactions only.					
	Or <input type="checkbox"/> Express consent for medication, allergies, adverse reactions and additional information.					
	No – I would NOT like a Summary Care Record <input type="checkbox"/> Express dissent for Summary Care Record (opt out).					
	Patients name:		Date of birth:			
			Patient postcode:			
	Surgery name:		Surgery location (town):			
	NHS number (if known):		Date:			
	Signature:					
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:						
<table border="1"> <tr> <td></td> <td>Parent</td> <td>Legal Guardian</td> <td>Lasting power of attorney for health and welfare</td> </tr> </table>				Parent	Legal Guardian	Lasting power of attorney for health and welfare
	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.

14	Signature	
	Patient signature:	Signature on behalf of patient:

Thank you for completing this form. For more information about the services we offer, please refer to our practice leaflet or see our website

Office use only

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 reaction 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

Registration Checklist

NOTE: Please ensure all relevant sections below have been completed by the registration clerk at the time of registration

Section:	Notes	Read Code	Staff member that completed section
Section 1	Ensure Name and Date of Birth of patient has been completed		Completed by:
	Task to Debbie to activate SMS consent via MJO		Completed by:
Section 2	Task to Debbie to add notes if patient is a carer or cared for		Completed by:
Section 3	Employment		Completed by:
Section 4	Ethnicity, Religion and Circumstances		Completed by:
Section 5	Lifestyle		Completed by:
Section 6	Diet and Exercise		Completed by:
Section 7	Send task to Kerry M to inform of all adult female registrations – ALL AGES FROM 16 YEARS OLD (Cervical screening)	Y1F4F	Completed by:
Section 8	Medical Background		Completed by:
Section 9	PPG		Completed by:
Section 10	Has patient been setup for online services and provided with log in details		Completed by:
Section 11	Electronic Prescription Service		Completed by:
Section 12	Other information such as blood donor and will		Completed by:
Section 13	If patient has consented for Summary Care record to be shared - action this.		Completed by:
Section 14	Signature	N/A	N/A
Read Code	Ensure read code for - Informing patient of named accountable general practitioner has been added.	Xab9D	Completed by:
Read Code	Ensure read code for - Patient allocated named accountable general practitioner has been added.	XacWQ	Completed by: