Name:	DoB:	Date:

The practice needs your express consent to use your data to help manage your care. The practice strongly recommends that you sign sections 1, 2 and 3 which will ensure you continue to receive the highest quality of health care.

***Data Sharing**

1. Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information, which includes: current medication, any allergies and any bad reactions to medication.

Please sign if you wish to opt-in of the Summary Care Record. Signature: ……

2. Enhanced Summary Care Record

This is the same as above where other important information can be shared i.e. Any health issues, illnesses, operations, vaccinations, next of kin or what support you may need.

Expressed consent given Signature: ……

Please sign if you wish to opt-in of the Enhanced Summary Care Record XaXbZ

3. Risk Stratification Preferences

Risk stratification is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Risk Stratification programme allows uploading of patient's identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.

Please sign if you wish to opt-in of the Risk Stratification programme.

Signature: …… (XabjB)

For more information please visit our website at www.theglenfieldsurgery.co.uk

The practice has no particular view as to whether you should consider sections 4 and 5.

4. Medical Interoperability Gateway (MIG)

Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.

For more information please visit the "Further Information" page on our website at:
www.theglenfieldsurgery.co.uk

Please sign if you wish to opt-in of the Medical Interoperability Gateway.

Signature: ……

5. National Data

National Data is anonymised data used by the Health Service and other agencies to plan care for population. Data of this type is used primarily for planning purposes.

If you wish to opt-out of National Data (which allows you to stop your confidential patient information from being used for purposes beyond your individual care) you should go to 'Your NHS Data Matters' website (www.nhs.uk/your-nhs-data-matters).

The Glenfield Surgery – Adult Registration Form

111 Station Road, Glenfield, Leicester, LE3 8GS
Tel: 0116 2333600, Web: www.theglenfieldsurgery.co.uk

Thank you for applying to join The Glenfield Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You must supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and a second proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.
Fields marked with an asterisk (*) are mandatory.

*Title *Surname	*First & other names
*Any previous surname(s) (if applicable)	*Date of Birth
* ☐ Male ☐ Female	NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and Country of birth:	*Home address *Postcode:
KEYSAFE (If you have one)	
Calling Name:	Email address:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	*Home telephone No.
	Alternative telephone No. e.g. Work(Please state)
Occupation: ☐ Employed ☐ Self Employed ☐ Retired ☐ Unemployed	*Mobile No. (if you have one) As a practice we will send text messages where appropriate, if you wish NOT to receive texts ☐ No

If you are from abroad please tell us the date you first came to live in the UK: If previously resident in UK, date of leaving:	Have you ever been in the employ of the Armed Forces? ☐ Yes ☐ No Date Enlisted: Date Left:

***Additional details about you**

*What is your ethnic group?				
White	☐ British	☐ Irish	☐ Other White (please specify):	
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):	
Asian	☐ Indian	☐ Pakistani	☐ Other Asian (please specify):	
Mixed	☐ White & Black Caribbean		☐ White & African	☐ White & Asian
If your preferred spoken language is NOT English please indicate what it is				

Previous G.P./ Surgery:

Next of kin/Emergency Contact

Name	Relationship to you
Next of kin/Emergency telephone number(s)	Next of kin address (if different to above)

Looked after Children

Are you looking after someone else's child? ☐ Yes ☐ No
If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order
☐ Child arrangement order/Residence Order ☐ Special Guardianship order ☐ Placed for adoption
☐ Private arrangement/Private Fostering/informal arrangement
(please note you have a duty to notify social care of this arrangement)

A 'carer' is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Do you have a Carer? ☐Yes ☐No
Name & Relationship:

Their contact details:

Do you consent for your carer to be informed about your medical care? ☐Yes ☐No (918F)

Are you a Carer? ☐Yes ☐ No (Ub1ju)
If yes, do you look after someone who is a patient of The Glenfield Surgery? ☐Yes ☐No ☐ Don't know
If yes, what is their name?

Are they a: ☐Relative ☐Friend ☐Neighbour ☐ Other (please specify)
Do you have Power of Attorney for this Person? ☐Yes ☐No

***Medical details**
Have you ever had any of the following conditions?

Epilepsy	☐ Yes	**Rheumatoid Arthritis**	☐ Yes
High Blood Pressure	☐ Yes	**Mental Illness**	☐ Yes
Heart Attack	☐ Yes	**Diabetes (type 1 or type 2)**	☐ Yes
Angina (stable / unstable)	☐ Yes	**Asthma**	☐ Yes
Stroke	☐ Yes	**COPD (or Emphysema)**	☐ Yes
Transient Ischaemic Attack	☐ Yes	**Osteoporosis / Bone Fractures**	☐ Yes
Cancer	☐ Yes	**Peripheral Vascular Disease**	☐ Yes
Hypothyroidism	☐ Yes	**Depression**	☐ Yes

Do you have any special needs regarding information or communication, (E.g. Deaf or visual impairment) please give details.
Do you communicate using BSL/deafblind manual/other:
Do you communicate using hearing aids / talking mat/other:
Do you need information in large print / braille/other:
If we need to contact you which would be the best way is text/ phone/ letter/ other

None of the above conditions ☐ yes

List any serious illnesses / operations / accidents (women: any pregnancy related problems) & the year they took place:	
Do you have any disabilities (whether you are registered disabled or not)	
Physical Disability – Please describe:	Learning Disability – Please describe:

Do you have a family history of any of the conditions below?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who

None of the above conditions ☐ yes

*Height ft/m in/cm	(**for women only**) Have you had a cervical smear? ☐Yes ☐No (*Please state where, when and the result if possible*)
*Weight st/kg lb/g	☐ Yes ☐ No Have you had a hysterectomy

Do you smoke? Yes ☐ No ☐ Never ☐

If Yes, what do you primarily smoke: **(please circle)** Cigarettes / Cigar / Pipe
How many do you smoke a day?

Are you an ex-smoker ☐ Yes ☐ No How many did you used to smoke a day?
When did you quit?

The best way of stopping smoking is with a combination of medication and support. For details of 'Smoking Cessation' clinics please call 03456466666.

Alcohol Consumption Questions

Do you drink alcohol ☐ Yes ☐ No
If yes please complete the questions below

(please circle your answers in the boxes below)	**Unit scoring system** **0**	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 3 times per week	4+ times per week
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 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

If you score 5 or more on the above please complete the questionnaire below - Above score ☐

Questions	**Scoring System** 0	**1**	**2**	**3**	**4**	**Your score**
How often in the last year have you found you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
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 or almost daily**	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often in the last year have you had a feeling of guilt or regret after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
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 or almost daily**	
Have you or someone else been injured as a result of your drinking?	**No**		**Yes but not in the last year**		**Yes during the last year**	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	**No**		**Yes but not in the last year**		**Yes during the last year**	

Scoring: 0-7= sensible drinking, 8-15= hazardous drinking, 16-19=harmful drinking, 20+ possible dependence.

TOTAL ☐

I am currently NOT taking any repeat medication ☐ yes

Repeat Medication Information – Please attach a repeat prescription request form from your previous G.P. if you have one.

Name of Medication	Strength (mg)	How Often Medication is taken

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Please record any additional information about you that you think is important for us to know

New Patient Health-check

…As part of our Practice policy we are offering a New Patient health-check with a Health Care Assistant to anyone aged 40 and over. If you should like to take this up please indicate below and you will be contacted.

I am over 40 and would like a New Patient Health Check appointment. YES / NO

Patient Access

On-line Services
Once your application to join our practice has been accepted you'll be able to register with our on-line service provider (SYSTMONE) and access appointments, prescriptions and view certain aspects of your medical records (DCR) via the internet. This service is known as **Patient Access**.

All of the details that you need for this are available on our practice website at …www.theglenfieldsurgery.co.uk ***or PLEASE SEE ATTACHED FORM TO REGISTER.***
This service is available to everyone with a valid email address.
We can only accept your request for Patient Access if your email address is valid and not shared by another person.

We aim to have patient's registered within 2-3 working days or less but, due to practice workloads this may take up to 5 working days.

If there are any problems with your registration we'll contact you to clarify any issues.

Print Name ***Sign**	***Date**

Signed on behalf of patient (*if applicable*)
(e.g. adults lacking capacity)

Relationship to Patient:

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE:** _____

ADDRESS ID ☐ **TYPE:** _____

Staff Name:…… **Date Accepted:** ……

Checked by …… **Date** ……

-

THE GLENFIELD SURGERY

Application for online access

Please supply two forms of identification with this form (one photo and one utility bill)

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number:	Mobile number:

***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 medical record (**Medication and Allergies Only**)	☐
4. If you want access to the 'Detailed Coded Records' (DCR) please speak to a receptionist	

PLEASE READ AND AGREE TO THE 'TERM AND CONDITIONS' BELOW

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	☐
6. That I am requesting access of my own free will and am not being coerced by a third party.	☐
If you require online access to medical records in the capacity of <u>parent/guardian</u> to someone under the age of 11, please complete below	
7. I understand that as the parent/guardian of a child I will only have access until the child reaches the age of 11 then my access rights are withdrawn.	☐
If you require online access to medical records in the capacity of carer or otherwise and children aged 11-16, please complete the attached for 'Patient proxy access'.	

Signature of Patient / Parent / Guardian (please indicate)	Date:

For Practice Use Only

Patient NHS number:		
Identity Verified by (staff initials):	**Date:**	**Form of ID:** Vouching □ Vouching with information in record □ Photo ID & Proof of Residence □
Scanned onto Patient's Records:		**Date:**

THE GLENFIELD SURGERY

APPLICATION FOR PROXY ACCESS TO ONLINE SERVICES FOR ADULTS AND CHILDREN AGED 11 - 16.

Patient details:

Surname ……..... Forename ……..……

Date of birth …….. NHS number ……

Address ……...

……

Telephone …….. GP details ……..

Nominated individual details:

Surname ……..... Forename ……..……

Date of birth …… NHS number ……

Address ……

……..

Telephone …… GP & practice details ……

Relation to patient ……

I give permission for my nominated individual to have proxy access to the online services as detailed below:

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I am aware that my GP may overrule my decision at any time and that this authorisation will remain in force until …./…./…. or until cancelled by me (in writing). I understand the risks of allowing someone else access to the online services detailed above.

Signature (of patient)	Date:

I agree that |I will treat all the information confidentially and will not disclose this information to any third party without the expressed permission of the person named as the patient above. I will only use this information in the best interest of the patient.

Signature (of nominated Individual)	Date:

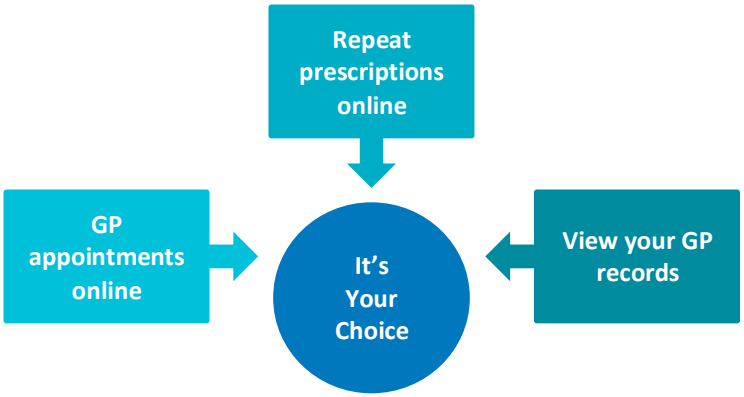
FOR PRACTICE USE ONLY

Patient NHS number:		
Identity Verified by (staff initials):	**Date:**	**Form of ID:** Vouching ☐ Vouching with information in record ☐ Photo ID & Proof of Residence ☐
Authorised by		**Date:**

Level of record access enabled: All □ Prospective □ Retrospective □ DCR □ Limited parts □	Notes/explanation

Online Services Records Access
Patient information leaflet 'It's your choice'

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for **some** of these services as well. It's your choice.



WHEN BOOKING AN APPOINTMENT ON LINE, AT PRESENT ONLY DOCTORS APPOINTMENTS AND FLU APPOINTMENTS (WHEN APPLICABLE) ARE AVAILABLE. PLEASE GIVE A BRIEF COMMENT REGARDING THE REASON FOR YOUR APPOINTMENT.

WHEN ORDERING REPEAT MEDICATION PLEASE LET THE PRACTICE KNOW IF YOU WANT YOUR MEDICATION TO GO TO A PARTICULAR PHARMACY (IF IT IS NOT STATED) AND IF YOU WANT THE PHARMACY TO DELIVER THE MEDICATION.

IF YOU WANT TO ORDER REPEAT MEDICATION EARLY DUE TO HOLIDAYS ETC OR WOULD LIKE TO ORDER OTHER MEDICATION YOU HAVE HAD PREVIOUSLY THAT ARE NOT ON REPEAT PLEASE USE THE 'CUSTOM REQUEST ' SECTION.

THE PRACTICE DOES NOT ACCEPT MEDICATION REQUEST ON THE TELEPHONE.

Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

You will be given login details, so you will need to think of a password which is unique to you. This will ensure that only you are able to access your record – unless you choose to share your details with a family member or carer.

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.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

The practice has the right to remove online access to services for anyone that doesn't use them responsibly.

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

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

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

It's up to you whether or not you share your information with others – 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
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf