

Name:	DoB:	Date:
Parent/Guardian:		

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 – Child Registration Form. (Under 16 years old)

111 Station Road, Glenfield, Leicester, LE3 8GS

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. **Please provide proof of address.**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure an adult **SIGNS** and **DATES** this form. **Fields marked with an asterisk (*) are mandatory.**

*Title	*Surname
Calling Name:	
* <input type="checkbox"/> Male <input type="checkbox"/> Female	
Town and Country of birth:	
School (if appropriate):	
Has the child registered with a G.P. previously? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Is the child a looked after child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>A child who is being looked after by their local authority is known as a child in care. They might be living: with foster parents, at home with their parents under the supervision of social services or in residential children's homes.</p>	

*First & other names
*Date of Birth
NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address
*Postcode:
*Home telephone No.
Contact Mobile No.
As a practice we will send text messages where appropriate, if you wish <u>NOT</u> to receive texts <input type="checkbox"/> No
Relationship to child:

***Additional details about the child**

*Ethnic group?			
White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other White (please specify):
Black	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other Black (please specify):
Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Other Asian (please specify):
Mixed	<input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> White & African	<input type="checkbox"/> White & Asian

Previous G.P. / Surgery:

If their preferred spoken language is <u>NOT</u> English please indicate what it is

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.

Is the child Cared for? <input type="checkbox"/> Yes <input type="checkbox"/> No	(918F)
Name & Relationship:	
Their contact details:	
Is the child a Carer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do they look after someone who is a patient of The Glenfield Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Is the child Fostered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Foster/Adoptive Parent's Names	
Has the child been Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(Ub1ju)	

Next of kin / Emergency Contact

Name of next of kin/Emergency contact

Relationship to Child

Next of kin/Emergency telephone number(s)

Next of kin address (if different to above)

***Medical details**

Does the child have any special needs regarding information or communication, (e.g. Deaf or visual impairment)
Please give details.

Do they communicate using BSL/deafblind manual/other:

Do they communicate using hearing aids / talking mat/other:

If we need to contact you which would be the best way is text/ phone/ letter/ other

Do they need information in large print / braille/other:

Has the child ever had any of the following conditions?

Epilepsy	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack / Angina	<input type="checkbox"/> Yes	Year
Stroke / Mini-stroke (TIA)	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year
Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year

Mental Illness	<input type="checkbox"/> Yes	Year
Diabetes	<input type="checkbox"/> Yes	Year
Asthma	<input type="checkbox"/> Yes	Year
COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Osteoporosis / Bone fractures	<input type="checkbox"/> Yes	Year
Peripheral vascular disease	<input type="checkbox"/> Yes	Year

None of the above conditions yes

List any serious illnesses / operations / accidents (Females: any pregnancy related problems) & the year they took place:

Does the child have any disabilities (whether they are registered disabled or not)

Physical Disability – Please describe:

Learning Disability – Please describe:

The child is NOT currently on 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

* Is the child allergic to any medicines? Yes No (if yes please specify)

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

Smoking Data **we are required to collect this data*

If the child is **14 or over and asthmatic** does he/she smoke?
 Yes No
 How many do you smoke a day?

If the child is **15 or over** does he/she smoke?
 Yes No
 How many do you smoke a day?

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

Does the child have family history of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who

DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Breast Cancer	<input type="checkbox"/> Yes	Who
Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Thyroid disorder	<input type="checkbox"/> Yes	Who
Epilepsy	<input type="checkbox"/> Yes	Who
Osteoporosis	<input type="checkbox"/> Yes	Who

None of the above conditions yes

IMMUNISATIONS

Immunisation	Date(s) Given	Immunisation	Date(s) Given
Diphtheria		MMR	
Polio		BCG	
Pertussis		Other (specify)	
HIB			

Please record any additional information about the child that you think may be important for us to know

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.

To be signed by an adult on behalf of patient. (Patient is a minor/under 16 years old)
 Name:
 Signature:
 Relationship to patient:

Date

FOR OFFICE USE ONLY

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	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record (Medication and Allergies Only)	<input type="checkbox"/>
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	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
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.	<input type="checkbox"/>
6. That I am requesting access of my own free will and am not being coerced by a third party.	<input type="checkbox"/>

If you require online access to medical records in the capacity of parent/guardian 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.	<input type="checkbox"/>
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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:
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For Practice Use Only

Patient NHS number:		
Identity Verified by (staff initials):	Date:	Form of ID: Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID & Proof of Residence <input type="checkbox"/>
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	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

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:
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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:
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FOR PRACTICE USE ONLY

Patient NHS number:		
Identity Verified by (staff initials):	Date:	Form of ID: Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID & Proof of Residence <input type="checkbox"/>
Authorised by	Date:	

Level of record access enabled: All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> DCR <input type="checkbox"/> Limited parts <input type="checkbox"/>	Notes/explanation
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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.

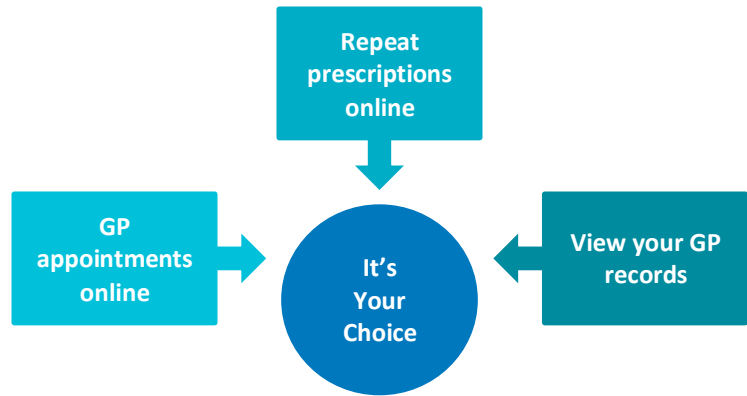
WHEN ORDERING REPEAT MEDICATION PLEASE LET THE PRACTICE KNOW IF YOU WANT YOUR MEDICATION TO GO TO A PARTICULAR PHARMACY (IF IT IS NOT STATED) AND IF YOU WANT THE PHARMACY TO DELIVER THE MEDICATION.

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>