Updated 31/10/2023

Taken By (office use only) …………………….

**New Patient Registration**

**We ask ALL newly registering patients to complete this questionnaire.**

All patients requesting to register with this practice need to complete and provide the requested information that is detailed below:

1. Patients need to provide a 10 digit NHS number. The NHS number is obtainable from your previous registered surgery.
2. As part of our online services registration, you will need to provide the following:

* Photo ID
* Proof of address

*If you are not able to provide all of this information at the time of registering this can be brought in at a later date.*

**GP Appointments**

We now offer a service called askmygp for all Doctors and Nurse Practitioner appointments, which can be accessed via our website [www.stjohnsmedical.co.uk](http://www.stjohnsmedical.co.uk) and then click on the askmygp link on our home page.

**AskMyGp**

Please detail your email address below so we can send you a welcome email for the askmygp service.

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION:**

To allow us to communicate with you in the most efficient, effective and convenient way possible we use SMS text messaging and email at St Johns Medical Centre.  This allows all staff to send an SMS text message or email to you directly from our clinical system with a copy of the message automatically being stored in your medical record. Please note children under the age of 16 years will not be able to receive SMS test messages.

**Do you consent to SMS:**

**Yes**

**No**

**FOR CHILDREN ONLY:**

St John’s Medical Centre has a duty to ensure that all children who are not deemed mature enough to consent for themselves and require treatment have consent to receive this treatment by someone with parental responsibility.

Please could you complete the form below (one for each child of the family registered) to inform who has parental responsibility:

|  |  |
| --- | --- |
| Childs First Name |  |
| Childs Surname |  |
| NHS Number |  |
| Date of Birth |  |
| Address |  |
| First Person With Parental Responsibility: Parent or Legal Guardian | |
| Name |  |
| Relationship to the Child |  |
| Address |  |
| Signature |  |
| Second Person with Parental Responsibility: Parent or Legal Guardian | |
| Name |  |
| Relationship to the Child |  |
| Address |  |
| Signature |  |

Please name any other person/s that you give consent, to bring your child to an appointment and make decisions regarding their care or treatment.

Name: Date of Birth:

Name: Date of Birth:

Please be aware that if a child presents with anyone other than those with parental responsibility or to those listed above, treatment may be withheld.

Where the person with responsibility is the parent, they must be named on the birth certificate to be deemed to have parental responsibility. Legal guardians must have the relevant paperwork showing their responsibility for the child. St John’s Medical Centre reserves the right to request proof of this responsibility at any time.

**QUESTIONNAIRE FOR ALL PATIENTS:**

Do you smoke? Yes / No

Have you ever smoked? Yes / No

Would you like help to stop smoking? Yes / No

When did you stop smoking ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many units of alcohol do you think you drink per week ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_ What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN OVER 25**

When was your last cervical smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a Hysterectomy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR NURSING HOME PATIENTS ONLY:**

What is the patients’ blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urine Dipstick result: Blood: \_\_\_\_\_\_\_\_\_\_\_ Protein: \_\_\_\_\_\_\_\_\_\_\_\_ Glucose: \_\_\_\_\_\_\_\_\_\_\_

**DO YOU HAVE/HAVE YOU HAD:**

Asthma Y/N Heart Attack/Angina Y/N

Diabetes (HCA)Part 1. Y/N Atrial Fibrillation Y/N

High Blood Pressure Y/N Stroke/ TIA Y/N

COPD Y/N

**ALL PATIENTS:**

**Are you on any regular medication? If so, please bring a list of your full medications. You can ask for a full list from your previous GP.**

**NEXT OF KIN:**

**Please enter details of next of kin –**

Name:

D.O.B

Relationship:

Address:

Telephone number:

**RECORD SHARING:**

Do you consent to the sharing of date recorded here at St Johns Medical Centre with any other organisations that may care for you.

Sharing out:

Yes – Share date with other organisations

No – Do not share any data recorded here

Sharing in:

Do you consent to the viewing of data by this organisation that is recorded at other care services that may care for you where you have agreed to make the data shareable?

Consent given

Consent refused

Please tick both sections

Signature……………………………….. Date…………………………………..

CARERS: A carer is a family member or helper who regularly looks after a friend or family member who can’t cope alone due to illness, disability, a mental health problem or an addition. We are keen to identify those who care for others (officially or unofficially) as we may be able to offer additional support to those individuals.

Are you a carer? Y / N Who do you care for?………………………………………………………..

Do you have a carer? Y / N Who is your carer?.................................................................................

**PREFERRED PHARMACY:**

If you would like your prescription sending to a pharmacy, Please select 1 pharmacy from the list below:

ASDA…………………………………………………………………………………………………………………………..

BARROWBY GATE PHARMACY (Lincoln Co-Op)…………………………………………….

BOOTS (Next Door from surgery) ……………………………………………………….………..

BOOTS (High Street)……………………………………………………………………………………..

GRANTHAM PHARMACY (High Street)………………………………………………………..

HARROWBY PHARMACY (New beacon road – Alma Park)……………………………

SUPERDRUG (Isaac Newton Shopping Centre – bus station)………………………..

WELL PHARMACY ……………………………………………………………………………………….

**ONLINE SERVICES:**

St John’s Medical Centre are pleased to be able to offer access to our online services, you can order repeat medications and view certain parts of your medical records.

We currently offer this service to all patients over the age of 16 years old.

If you wish to sign up for this service at the time of registering with the Practice, please complete the information requested below and hand in this form with your registration documents and identification.

**You will be required to use your online log-in details to register online immediately, your log-in details will expire if unused.**

PLEASE PRINT YOUR EMAIL ADDRESS …………………………………………………………..

Signed: Dated:

Print Name:

Date of Birth:

**THIRD PARTY CONSENT:**

**ONLY COMPLETE IF YOU WISH A THIRD PARTY TO DISCUSS YOUR RECORDS ON YOUR BEHALF.**

Name ……………………………………………………………………………………..

Date of Birth …………………………………………………………………………..

**I hereby give consent for the following named person to discuss my medical records**

Name …………………………………………………………………………………….

Relationship …………………………………………………………………………

Telephone No……………………………………………………………………….

Signature……………………………………………………………………………..

Date……………………………………………………………………………………..

**Your Summary Care Record**

**Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those involved in your care with faster secure access to key information from your GP record.**

***What is a SCR?***

If you are registered with a GP practice in England, you will already have an SCR unless you have previously chosen not to have one. It includes the following basic information:

 Medicines you are taking

 Allergies you suffer from

 Any bad reactions to medicines.

It also includes your name, address, date of birth and unique NHS Number which helps to identify you correctly.

***What choices do you have?***

**You can now choose to include more information in your SCR**, such as significant medical history (past and present), information about management of long term conditions, immunisations and patient preferences such as end of life care information, particular care needs and communication preferences.

**If you would like to do this, talk to your GP practice as it can only be added with your permission.**

Remember, you can change your mind about your SCR at any time. Talk to your GP practice if you want to discuss your option to add more information or decide you no longer want an SCR.

***Vulnerable patients and carers***

Having an SCR that includes extra information can be of particular benefit to patients with detailed and complex health problems. If you are a carer for someone and believe that this may benefit them, you could discuss it with them and their GP practice.

***Who can see my SCR?***

Only authorised care professional staff in England who are involved in your direct care can have access to your SCR. Your SCR will not be used for any other purposes.

These staff

 Need to have a Smartcard with a chip and passcode

 Will only see the information they need to do their job

 Will have their details recorded every time they look at your record.

**Care professionals will ask for your permission if they need to look at your SCR.** If they cannot ask you because you are unconscious or otherwise unable to communicate, they may decide to look at your record because doing so is in your best interest. This access is recorded and checked to ensure that it is appropriate.

***SCRs for children***

If you are the parent or guardian of a child under 16, and feel they are able to understand this information you should show it to them. You can then support them to come to a decision about having an SCR and whether to include additional information.

***Confidentiality***

For information on how the NHS will collect, store and allow access to your electronic records visit NHS Choices at www.nhs.uk/records.

For more information talk to the staff at your GP practice or visit www.hscic.gov.uk/scr/patients

You can also phone the Health and Social Care Information Centre (HSCIC) on 0300 303 5678

**OPT-OUT FORM**

**Request for my clinical information to be withheld from the Summary Care Record**

**If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice**

**………………………………………………………………………………………………….**

**A. Please complete in BLOCK CAPITALS**

Title ..................................................... Surname / Family name……………………………………............

Forename(s) ..................................................................................................................................................................

Address ..................................................................................................................................................................

..................................................................................................................................................................

Postcode .............................................. Phone No ............................................ Date of birth

.

NHS Number (if known) ....................................................................................... Signature

..................................................................................................................................................................

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request.

Please ensure you fill out their details in section A and your details in section B

Your name .................................................................................................... Your signature …………....

Relationship to patient ....................................................................................Date ………………………

**What does it mean if I DO NOT have a Summary Care Record?**

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and, any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone

If you have any questions, or if you want to discuss your choices, please contact your GP practice

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FOR NHS USE ONLY.

Actioned by practice yes/no Date……………………………….

FOR NHS USE ONLY.