|  |
| --- |
| **Patient Details** |
| **Forename/s:**  | **Surname:**  |
| Male [ ]  Female [ ]  | **Date of Birth:**      /     /      |
| **NHS number:**       | **Place of Birth:**  |
| **Address:**       |
| **Postcode:**  | **Phone Number:**       |
| **First Language:**  | **Email Address:**  |

|  |
| --- |
| **PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION** |
| **Previous UK Address:**  |
| **Postcode:**       | **Previous GP Surgery:**  |
| **Have you recently arrived into the UK:** Yes [ ]  No [ ]  **If yes date of arrival:**       |

|  |
| --- |
| **MEDICAL INFORMATION** |
| **Allergy to any medication?** Yes [ ]  No [ ]  *If yes details:*       |
| **Any other allergies?** Yes [ ]  No [ ]  *If yes details:*       |
| **Any medical conditions?**  |
| **Any regular medication?**  |

|  |
| --- |
| **IMMUNISATIONS – PLEASE GIVE DATES** *(CHILDREN UNDER 6)* |
| **Eight weeks:** Click here to enter a date. | **Twelve weeks:** Click here to enter a date. |
| **Sixteen weeks:** Click here to enter a date. | **One year:** Click here to enter a date. |
| **Any other:**  | **2-6 years:**  |

|  |
| --- |
| **FAMILY HISTORY** – *Is anyone in your immediate family affected by any of the following:* |
| Asthma [ ]  | Diabetes [ ]  | Glaucoma [ ]  | Blindness [ ]  |
| Tuberculosis [ ]  | Heart Disease [ ]  | Infectious Disease [ ]  | Hypertension [ ]  |
| Epilepsy [ ]  | Thyroid Disease [ ]  | Cancer [ ]  type (if known)       |
| **Other (please specify)**  |

|  |
| --- |
| **PARENT/GUARDIAN INFORMATION** |
| 1 | Name:       | Relationship to Child:       |
| Address (if different):       |
| Phone Number:       | Parental Responsibility: Yes [ ]  No [ ]  |
|  |
| 2 | Name:       | Relationship to Child:       |
| Address (if different):       |
| Phone Number:       | Parental Responsibility: Yes [ ]  No [ ]  |

|  |
| --- |
| **EDUCATION** |
| School/Nursery name (if applicable):       |
| Address:       |

|  |
| --- |
| **HEALTH PROFESSIONALS** |
| **Does your child have contact with any of the following?** |
| Hospital Specialist/Consultant [ ]  | Health Visitor [ ]  |
| Social Worker [ ]  | Other (please state)       |
| Has your child ever been subject to a Child Protection plan? Yes [ ]  No [ ]  |

|  |
| --- |
| **ELECTRONIC PRESCRIBING (EPS)** |
| Which pharmacy would you like prescriptions sent to?       |

|  |
| --- |
| **ETHNICITY** |
| **Ethnic Category** |  | **Please tick** |  | **Please tick** |
| **White** | British | [ ]  | Irish | [ ]  |
|  | Other White | [ ]  |  | [ ]  |
| **Mixed** | White & Black Caribbean | [ ]  | White & Black Asian | [ ]  |
|  | White & Asian | [ ]  | Other Mixed | [ ]  |
| **Asian/Asian British** | Indian | [ ]  | Bangladeshi | [ ]  |
|  | Pakistani | [ ]  | Sri Lankan | [ ]  |
|  | Other Asian | [ ]  | Korean |  |
| **Black/Black British** | Black Caribbean | [ ]  | Black African | [ ]  |
|  | Other Black | [ ]  |  |  |
| **Other** | Chinese | [ ]  | Arab | [ ]  |
|  | Other Ethic Category | [ ]  | Not Stated | [ ]  |

|  |
| --- |
| **ACCESSIBLE INFORMATION STANDARD** |
| The accessible information standard means that all providers of NHS care must try to ensure that they communicate with disabled patients in an appropriate way. As part of our obligation to meet this standard, we would ask you to answer the following questions. |
| 1. Would you consider that you have a disability that means you have specific communication and/or information needs?

Yes [ ]  (please go to question 2) No [ ]  (please go to ‘Recording Consent of Patients) |
| 1. Please tell us your disability

Visual Impairment [ ]  Hearing Impairment [ ]  Speech Impairment [ ]  Other [ ]  |
| 1. Based on the answer to question 2, what would be your preferred method of contact from the practice?

Email [ ]  Large Print Letter [ ]  Braille [ ]  BSL Interpreter [ ]  |
| **RECORDING CONSENT OF PATIENTS FOR DATA SHARING INITIATIVES IN KINGSTON** |
| **EMIS Sharing** | EMIS Sharing enables your local Kingston Care Providers, when they are treating you to view the relevant information about the care you receive, to give you the best possible care. | Opt out of Emis Sharing [ ] 93C1 |
| Opt in to Emis Sharing [ ] 93C0 |
| **Summary Care Record*****SCR logo ranged left no strapline*** | If you have a Summary Care Record, your health care providers can view your:* Medication (last 12 months)
* Bad Reactions to medicines
* Allergies

When you’re admitted to hospital, when treating you in an emergency or when your practice is closed. | Opt in Summary Care Record [ ]  |
| Opt out summary Care Record [ ]  |

|  |  |
| --- | --- |
| **Parent/Carer Name:**  |  |
| **Signature:** |  |
| **Date:** |  |

|  |
| --- |
| **PATIENT DECLARATION** – **for all patients who are not ordinarily resident in the UK** |
| Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being, in most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK.Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.More information on ordinarily residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP Practice.**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment, even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.****Please tick one of the following;**1. [ ]  I understand that I may need to pay for NHS treatment outside of the GP Practice
2. [ ]  I understand I have a valid exemption from paying for NHS treatment outside of the GP Practice. This includes for example, an EHIC or payment of the Immigration Health Charge (“the surcharge”), when accompanied by a valid visa, I can provide documents to support this when requested.
3. [ ]  I do not know my chargeable status

I declare that the information I give on this form is correct and complete, I understand that if it is not correct, appropriate action may be taken against me.**A parent/guardian should complete the form on behalf of a child under 16.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Print Name:** |  | **Relationship to patient:** |  |
| **On behalf of:** |  |

 |
| **Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK** |
| NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS |
| Do you have a non-UK EHIC or PRC? | Yes: [ ]  No: [ ]  | If yes, please enter details from your EHIC or PRC below: |
| Image result for ehic card | Country Code: Image result for european union symbol |       |
| 3: Name |       |
| 4: Given Names |       |
| 5: Date of Birth | DClick here to enter a date.D MM YYYY |
| 6: Personal Identification Number |       |
| 7: Identification number of the institution |       |
| 8: Identification number of the card |       |
| 9: Expiry Date | Click here to enter a date. |
| PRC validity period (a) From: | DD MM YYYY |  (b) To: | DD MM YYYY |
| Please tick [ ]  if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state) **Please give your S1 form to the practice staff.** |
| **How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. |

**PATIENT / CARER CONFIDENTIALITY FORM**

Dear Patient

The practice is committed to maintaining patient confidentiality and will only discuss personal details and medical records with the patient. If you would like another individual to have access to this information please complete the consent.

|  |
| --- |
| ***PATIENTS DETAILS*** |
| **Surname:** |  | **Forename:** |  |
| **Date of Birth:** |  | **NHS Number:** |  |
| **House No/Street:** |  | **County:** |  |
| **Town or City:** |  | **Postcode:** |  |
| **Phone No.** |  | **Named GP:** |  |
| ***PARENT/CARER DETAILS*** |
| **Surname:** |  | **Forename:** |  |
| **Date of Birth:** |  | **NHS Number:** |  |
| **House No/Street:** |  | **County:** |  |
| **Town or City:** |  | **Postcode:** |  |
| **Phone Number:** |  | **GP & Practice** |  |
| **Email Address:** |  |
| **Relationship to Patient:** |  |

I give permission for the above named individual to have access to my medical records and personal details held by the Practice and for staff to discuss this with them.

The permission relates to all of my medical records including but not limited to medication, appointments, referrals and test results.

I understand that this consent will remain in force until I reach 16 years old. However, my doctor may override this authority and remove access to specific items if they feel it is in my best interest.

|  |  |
| --- | --- |
| **Signed (patient):** |       |
| **Date:** |       |