## The Orchard Partnership



Adult Confidential Medical Registration Form

## Drs HL Meader, LM Macready, JM Banfield, HV Pickup, AR Corke, HRL Bond, SJ Butcher and L Kinlin

Please complete all pages in full using block capitals and black ink

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Names (in full): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Surnames: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Landline number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ 🞏 Male 🞏 Female

NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town & country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where you have provided information and ticking the consent box below you are agreeing to The Orchard Partnership contacting you by text message, email or voicemail (using your landline number) for the purpose of appointment reminders, results, action needed following test results, referrals, health promotions, non NHS work, medication and Practice updates.

I acknowledge that text messages, emails and voicemails are an additional service and that they may not be sent on all occasions. The responsibility for attending appointments and cancelling them as well as contacting the Practice to obtain the results of recent tests still rests with me. I can cancel the text message and/or email facility at any time.

Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. Emails and voicemail will also be generated using a secure facility but I understand that they are transmitted over a public network onto personal email accounts or landlines and as such may not be secure. We will only send the minimum amount of personal identifiable information needed to convey the message.

SMS and email is our preferred method of communication and will be used in the first instance, however, if you do not use/have a mobile telephone or email account, we may leave voicemails via your landline. Please note that voicemails are left only when the Practice must get in touch with you. It therefore is not available for appointment reminders or cancellations.

Consent to receive communication

By email 🞏 Yes 🞏 No This will be to send you letters, newsletters and the like

By text 🞏 Yes 🞏 No This will be to send you reminders of appointments and other surgery information via text

Voicemail 🞏 Yes 🞏 No

Please Tick Your Preferred Communication MethodLetter Email Text

🖵 Please issue me with online logon details so I can order my medication, book appointments and view my medical record. Photo ID is needed. (A username and password will either be sent by SMS or left in reception for you to collect).

Your Data Matters to the NHS - Information about your health and care helps us to improve your individual care, speed up diagnosis, plan your local services and research new treatments. The NHS is committed to keeping patient information safe and always being clear about how it is used. How your data is used - Information about your individual care such as treatment and diagnoses is collected about you whenever you use health and care services. It is also used to help us and other organisations for research and planning such as research into new treatments, deciding where to put GP clinics and planning for the number of doctors and nurses in your local hospital. It is only used in this way when there is a clear legal basis to use the information to help improve health and care for you, your family and future generations.

Wherever possible we try to use data that does not identify you, but sometimes it is necessary to use your confidential patient information. If you are happy for your confidential patient information to be used for research and planning, you do not need to do anything. To find out more about the benefits of data sharing, how data is protected, or to make/change your opt-out choice visit [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)

Do you cosnent to your GP health record being made available to other NHS care services that Care for you?

🞏 Yes (recommended) 🞏 No, never

Do you consent to your GP Practice viewing your health record from other services that care for you?

🞏 Yes (recommended) 🞏 No, never

Please help us trace your previous medical records by providing the following information:

Your previous address in UK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of previous Doctor surgery while at that address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of previous Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did you last receive treatment? Eg *GP, Walk in Centre, MIU, Emergency Department etc*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

If you are from abroad:

Your first UK address where registered with a GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If previously resident in UK date of leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date you first came to UK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you need your doctor to dispense medicines & appliances:

For Dispensing Practices only:

* I live more than 1 mile in a straight line from the nearest chemist

If you are not a dispensing patient please specify which chemist you would ike to collect your medication from:

Name of chemist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are returning from the Armed Forces

Addresss before enlisting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enlistment date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of leaving service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service/ Personnel number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us about yourself:

Are you a carer? 🞏 Yes 🞏 No Do you have a carer? 🞏 Yes 🞏 No

If yes, please tell us the name & address of your Carer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your carer’s contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy for us to contact your carer about your health and/or medication? 🞏 Yes 🞏 No

Personal Medical History

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition Year diagnosed Ongoing

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

Family history

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following:

(please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

Immunisations

|  |  |  |  |
| --- | --- | --- | --- |
| Immunsation | Year | Immunisation | Year |
| Tetanus |  | Polio |  |
| Typhoid |  | Yellow Fever |  |
| Hepatitis A |  | Hepatitis B |  |

Please list any allergies you have to any drugs/medication:

Name of medication What was the problem or upset?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of current medication - if you have a copy of your repeat medication, please pass to reception to copy

Name of medication Dosage

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lifestyle

Please enter your height & weight Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lifestyle smoking:

Do you smoke: 🞏 Yes 🞏 No If yes, do you smoke: 🞏 Cigarettes 🞏 Cigars 🞏 Pipe

Are you an ex-smoker? 🞏 Yes 🞏 No When did you give up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cigarettes/ cigars do you smoke daily?

🞏 <1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

If you smoke a pipe how many ounces a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like help to quit smoking? 🞏 Yes 🞏 No

Lifestyle alcohol:

Do you drink alcohol: 🞏 Yes 🞏 No If yes, please answer the following questions:

How often do you have a drink that contains alcohol?

 🞏 Never 🞏 Monthly or less 🞏 2-4 times per month 🞏 2-3 times per week 🞏 4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?

🞏 1-2 🞏 3-4 🞏 5-6 🞏 7-8 🞏 10+

How often do you have 6 or more standard drinks on one occasion?

 🞏 Never 🞏 Less than monthly 🞏 Monthly 🞏 Weekly 🞏 Daily or almost daily

Lifestyle exercise:

Do you exercise: 🞏 Yes 🞏 No If yes, please answer the following questions

What exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female patients only

Are you currently, or think you may be pregnant? 🞏 Yes 🞏 No

Do you have any children? 🞏 Yes 🞏 No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which method of contraception (if any) are you using at present? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a cervical smear test? 🞏 Yes 🞏 No Date if known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what was the result? (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Decline to state

Next of kin details to be held on your file:

Their name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that the information I have provided is true to the best of my knowledge

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient 🞏 Signature on behalf of patient 🞏

Please use the link below if you wish to register your wishes about Organ Donation:

[https://www.organdonation.nhs.uk](https://www.organdonation.nhs.uk/)

**Summary Care Record**

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 that 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.

1. Express consent for medication, allergies and adverse reactions only.You wish to share information about medication, allergies and adverse reactions only.
2. Express consent for medication, allergies, adverse reactions and additional information.You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.
3. Express dissent for Summary Care Record (opt out).Select this option, if you do notwant any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

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

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose **one** of the options below:

Yes – I would like a Summary Care Record

□ Express consent for medication, allergies and adverse reactions only

**or**

□ Express consent for medication, allergies, adverse reactions and additional information

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record (opt out)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For patients to complete who are not ordinarily resident in the UK



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**Office use: scan and send this page of form to:** NHSDigital-EHIC@nhs.net