**Logo, company name

Description automatically generatedBRIDGE VIEW MEDICAL**

Please help us to help you by answering as many of the following questions that you can. All answers will be treated as confidential and only used by healthcare professionals directly involved in your care. Please remember to give us a BP reading you can find a BP machine in the waiting room at each surgery

Title: First Name(s): Family Name:

Date of Birth:

Address(including postcode):

Home phone number: Mobile phone number:

Work phone number: Email address:

**Online Access**

If you would like to access online services you will need to show some form of **photo ID**:

ID Seen:

Staff Signature:

Please indicate which services you would like to access:

|  |  |
| --- | --- |
| Make Appointments | Yes No |
| Request Repeat Prescriptions | Yes No |
| Would you like to access information that is held in coded form on your medical records? | Yes No |

**Your communication preferences**

Please let us know how we can communicate with you:

|  |  |
| --- | --- |
| Can we leave a voice message on your landline? | Yes No |
| Can we leave a voice message on your mobile? | Yes No |
| Can we send you a text message?\* | Yes No |
| Can we send you appointment reminders via text?\* | Yes No |
| Can we send you your results by text? | Yes No |

\*We are unable to send reminders or results if you say no to receiving texts

Please tell us the name, address and contact number of your next of kin:

Name: Relationship to you:

Contact number:

Address:

What is your ethnic origin (please tick)?

**Asian or Asian British: White:**

BangladeshiBritish

Indian Irish

Pakistani Gypsy

Asian other (please state) Traveller

White other (please state)

**British or Black British: Other ethnic group:**

AfricanChinese

Caribbean Any other (please state)

Black other (please state)

**Mixed background:** **Other mixed background (please state)** **Rather not say**

White and Asian

White and Black African

White and Black Caribbean

What language do you usually speak and/or read?

Do you need an interpreter (including BSL)? Yes No

Do you consider yourself disabled? Yes - If so, please give details No

(If you have a disability, impairment or sensory loss we would like to make sure that you can access information in a format that you understand. Please let us know if we can provide communication support.)

Do you have a carer? Yes – please give carers name and address No

Are you a carer? Yes No – If yes, what is the name of the person you care for?

(If yes then please ask for a carer’s pack from reception)

**Health and Medication**

What is your height? What is your weight?

Please provide an up-to-date blood pressure reading, if you don't own a BP monitor, we have BP monitors in our waiting rooms at each BVM site. Please hand the reading into the front desk with your name on it.

Are you allergic to any medication, food or other substances?

Have you been seeing your previous family doctor or a specialist for any condition? If so please give further details of condition, and approximately when.

Have you had any surgical operations or other conditions serious enough to require hospital admission? If yes, please give details of condition and when (approximately).

Have you spent any prolonged periods or had medical treatment abroad? If yes, please provide details.

Is there a history of illness in your family such as asthma, diabetes, high blood pressure, stroke, cancer? Please give details.

What medication do you use regularly? (Include creams, drops, inhalers, etc.)

(or let us have a copy of your medication list). ***It is important that you answer this question, if you do not normally use any prescribed medication please add “None”.***

|  |  |
| --- | --- |
| Medication: | Reason for taking it: |
|  |  |
|  |  |
|  |  |
|  |  |

Do you normally receive your medication dispensed in a Medication Compliance Aid (aka “dossette box”)?  Yes (Please inform our practice pharmacist)  No

Do you take any non-prescription drugs or medication?

We use the electronic prescribing service which means once your prescription has been authorised we can send it directly to a chemist of your choice. What chemist would you like your medication sent to? Please add the name AND address of the chemist.

**Lifestyle**

Do you smoke? Yes- How many per day Ex-smoker No

If yes, would you would be interested in giving up smoking (we offer support to stop smoking here at the surgery)? Yes No

Do you drink alcohol? Yes No

How many units per week? (1 pint of beer or medium glass of wine is 2 units)

**Military** - **Serving** / **Veteran or Dependant**

Are you currently serving in the British Armed Forces? Yes No

Are you a Military Veteran of the British Armed Forces? Yes No

Which arm of the Services?

Have you ever been deployed on operations e.g. OP TELIC / Herrick? Yes No

Are you a dependant of a current serving member of the British Armed Forces?

Yes No

Are you a dependant of a former serving member of the British Armed Forces? Yes No

Please use this space below to tell us anything else you feel is relevant to the health care we provide.

**Shared care Record:** Some of the information you give on this form may be used as part of your Shared Care Record. The Summary Care Record is an electronic record of important patient information. It can be seen and used by authorised staff in other areas of the health and care system involved directly in your care. Form on next page

**Your Data Matters to the NHS**

**National Data Opt Out:** The national data opt-out is a service that allows patients to opt out of their confidential patient information being used for research and planning. You can change your choice at any time. To find out more or to make your choice visit nhs.uk/your-nhs-data-matters or call 0300 303 5678.

Form at end with further information leaflet.

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

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 NOT** want 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.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

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 and return the completed form to your GP Practice:

**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).

Name of Patient: ………………………………..…...............................................................

Address: ………………………………………………………………………………………

Postcode: ………………………………………… Date of Birth: ………..............................

NHS Number (if known): …………………………..……..................................................

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

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………....................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney for health and welfare.

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: <https://www.nhs.uk/your-nhs-data-matters/>

You can use this form to:

* register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
* withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

### This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

**Details of the patient**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** |  | | | | | | | | | |
| **Forename(s)** |  | | | | | | | | | |
| **Surname** |  | | | | | | | | | |
| **Address** |  | | | | | | | | | |
| **Phone number** |  | | | | | | | | | |
| **Date of birth** |  | | | | | | | | | |
| **NHS Number (if known)** |  |  |  |  |  |  |  |  |  |  |

**Details of parent or legal guardian**

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Relationship to patient** |  |

#### Your decision

**Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes except their own care.

**Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above’s identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

### **Your declaration**

I confirm that:

* the information I have given in this form is correct
* I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

**Signature**

**Date signed**

**When complete, please post or send by email to your GP practice**

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**For GP Practice Use Only**

|  |  |  |
| --- | --- | --- |
| Date received |  | |
| Date applied |  | |
| Tick to select the codes applied | **Opt – Out - Dissent code:**  9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|) |  |
|  | **Opt – In - Dissent withdrawal code:**  9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)] |  |

