**THE UPSTAIRS SURGERY**

**You MUST have completed the check list before emailing your registration forms to us. Please ensure all the forms are attached when returning to us. Registrations cannot be processed if they are not correctly completed.**

**REGISTRATION CHECK LIST:**

|  |  |
| --- | --- |
| **Form** | **Completed**  |
| **Completed GMS1 Form**  | **Yes/No** |
| **Completed Patient Registration Questionnaire** | **Yes/No** |
| **Completed Patient Online Access Form** | **Yes/No** |
| **Photo of individual holding Photo ID (e.g passport)** | **Yes/No** |
| **Proof of address (e.g utility bill, tenancy agreement etc) – Over 18s only.** | **Yes/No** |
| **For children photo of Red Book immunisation history** | **Yes/No** |

**Patient Registration Questionnaire**

**Welcome to the The Upstairs Surgery – We promote an environment of respect and tolerance.**

**If you are over 30 (or under with a medical condition) you will be booked a New Patient Registration appointment with one of our Practice Nurses (during these times this will be via a telephone consultation)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | Emergency contact name |  |
| Name |  |  |  |
| Date of Birth |  |  | Relationship to you? |  |
| Mobile No. |  |  | Phone No. |  |
| Home No. |  |  | Your Ethnicity? |  |
| Email |  |  |  |

**Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever suffered from… (Please circle)** |  |  | **Has a member of your family ever suffered from..** |
| Asthma | Stroke |  |  | Asthma | Cancer |  |
| COPD | Epilepsy |  |  | COPD | Stroke |  |
| Other chest problem | Depression/anxiety |  |  | Other Chest problem | Epilepsy |  |
| Diabetes | Had an operation |  |  | Diabetes | Mental Health problem |  |
| Heart problems | Other (please specify) |  |  | Heart problems | Other (Please specify) |  |
| High Blood pressure |  |  |  | High Blood pressure |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current medication. Please include doses, and attach a list if necessary** |  |  |  | **Allergies**  |  |
|  | Name |  | Dose |  | How often do you take? |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
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**About You**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you a parent? | Yes | No | If so, do your children live with you? | Yes | No |
| It is hard being a parent, and even harder to ask for help - We have lots of ways to support you, would you like help with any part of parenting? | Yes | No |
|  |  |  |
| Are you a carer for anyone with a medical condition who would not manage without your help? | Yes | No |
| Do you have a carer? | Yes | No | If yes, Carers name: |  |  |
|  |  |  |  |
|  |  |  |  |  |  |
|  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |
| Do you smoke? | Yes | No | Used to | Use e-cigarette or vaporiser |  |
|  |  |  |
| If you smoke, how much tobacco do you consume daily? |  |  |
|  |  |
| We have lots of ways to support you in stopping, is this something you would be interested in? | Yes | No |
|  |  |  |
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|  |  |  |  |  |  |
| Do you consume alcohol? | Yes | No | If yes, how much per week? |  |  |
|  |  |  |  |
| Would you like any help with drug or alcohol problems? | Yes | No |
|  |  |  |
|  |  |  |

**MOBILE TEXT MESSAGING SERVICE**

We have a 2-way text messaging service that:

* Send appointment reminders to patients
* Allows patients to text back should they need to cancel their appointments
* Allow surgery to send any actions required on patients test results
* Allow surgery to send out health campaigns

**By providing us with your mobile number you are automatically opted into the service.**

Please tick here if you wish to opt out 🞏

|  |  |  |
| --- | --- | --- |
|  |  |  |

**PLEASE COMPLETE NEXT PAGE**

**FOR ONLINE ACCESS.**

**THE UPSTAIRS SURGERY**

**Chadwell Heath Health Centre**

**Consent for Patient Access**

At The Upstairs Surgery we offer our patients online access to book appointments for the doctor, order their repeat prescriptions and view your GP medical record online to look at your medical history, past and current medication and your allergies.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up and operate the service.

The following form will take you through the things you need to think about. We have provided a detailed guide about online access to medical records and which you should also read before completing this declaration.

By signing this form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way. Photographic I.D. must be provided, you will then be given an access code and password to log onto the NHS App or other providers.

**Patient Details**

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name(s)** |  |
| **Date of Birth** |  |
| **NHS Number** |  |
| **Address** |  |
| **Telephone Number** |  |
| **Mobile Number** |  |
| **Email\*** |  |

**\*** If this email account is shared with others, please consider whether you agree that it can be used to send you confidential information about your account/services used.

## I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Limited access to parts of my medical record
 | 🞏 |

**Declaration (*please tick response as appropriate*)**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| 1. I agree to my GP Practice giving me access to my record online. |  |  |
| 2. I have read and understood the patient guide about online access to medical records and test results. |  |  |
| 3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the Practice. If not access may be withdrawn. |  |  |
| 4. If I see information which does not relate to me, I will immediately log out and report the matter to the Practice as soon as possible. |  |  |
| 5. I agree that it is my responsibility to keep my username and password secure. If I think these have been shared inappropriately, I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record. |  |  |
| 6. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved. |  |  |
| 7. I understand that online access is granted at the discretion of the Practice, taking into account my best interests. I will be informed of any decision not to provide access or withdraw access. Please note, this does not affect your rights of Subject Access under the Data Protection Act. |  |  |

**Other considerations**

The Practice makes every effort to record information as accurately as possible, however, there may be information that you do not feel is correct.

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| 1. If I notice any inaccuracies with my record, I will inform the Practice as soon as possible of any errors or omissions. |  |  |
| 2. I understand that I may see information on my record that I was unaware of or have forgotten about that could cause me distress. |  |  |
| 3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the Practice. If not access may be withdrawn. |  |  |
| 4. I understand that, as before, I will be informed by the Practice of any test results that require action. However, I understand that I may see these results online before the Practice has been able to contact me. This could be while the Surgery is closed and there is no one available to discuss with me. |  |  |

Once you have completed this form, your usual GP will review your medical records. This is to check that there is no information that your GP thinks you may have forgotten about or may find distressing. Your GP will either authorise access to your records or may, in the circumstances above, ask you to attend a consultation to discuss information in your records before authorising access.

Once access to your records has been authorised by you usual GP, we will contact you to inform you that your access has been set up. Please remember to keep all your account details secure.

If you have any queries or concerns about your records or the service or wish to withdraw from the service, please ring us on 0208 5971840

To be signed and then emailed to theupstairssurgery@nhs.net with photo of yourself holding your photo ID. :………………………………………………

Date: ……………………………………………

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

**For Practice Use**

Photo I.D. Shown: [ ]  Date:\_\_/\_\_/\_\_\_\_ Identity verified by (initials):….

GP authorised: Yes/No

Name of GP …………………………………………………..

Date: …………………………………………………..

Account enabled by: …………………………………………………..

Date: …………………………………………………..

Patient informed: Yes/No

Date: ………………………………………………….