This form is to register as an NHS patient with Sunbury Health Centre Group Practice.
Please complete the details below in CAPITALS and delete as appropriate at the *.
Once completed **please bring to the practice reception with photo ID and proof of address.**
You can expect to be registered within 21 days.
Please ensure you have enough medication from your previous surgery as you will need to see a GP before any can be prescribed.

Have you been registered with Sunbury Health Centre before? Yes / No *(please circle)*

*Mr / Mrs / Miss / Ms _____ **Surname** _____

Date of Birth | D | D | M | M | Y | Y | Y | Y |

First Name(s) _____

NHS No _____ Previous Surname(s) _____

***Male / Female** _____ Town & Country of Birth _____

Home Address _____

_____ **Postcode** _____

Phone Number: **Home** _____ **Work** _____ **Mobile** _____

Email Address: _____

Ethnic Group (*please circle*)

British or Mixed British **I**rish **W**hite Other **C**aribbean **A**frican **A**sian **M**ixed Other **I**ndian **P**akistani **B**angladeshi **B**lack Other **C**hinese **O**ther (*please specify*) _____

First language: English - **Yes / No** If **No**, please specify _____

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

Your previous address in UK _____

_____ Postcode _____

Name of previous doctor _____

Address of previous doctor _____
Postcode _____

If you are from abroad

Your first UK address when registered with a GP _____

If previously resident in UK, date of leaving _____ Date you first came to live in the UK _____

If you are returning from the Armed Forces

Address before enlisting _____

Service or personnel number _____ Enlistment date | D | D | M | M | Y | Y | Y | Y |

If you are registering a child under 5, please tick if appropriate

☐ I wish the child above to be registered for Child Health Surveillance

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. **Please circle** as appropriate:

• Kidneys • Heart • Liver • Corneas • Lungs •Pancreas •Tissue • Any part of my body

Signature confirming consent to organ donation

_____

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

---

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register

_____ Date

D	D	M	M	Y	Y	Y	Y

For more information, please visit the National Blood Service website www.blood.co.uk

My preferred address for donation is: (*only if different from your current address, e.g. your place of work*)

_____ Postcode:_____

Accessible Information Standard – Overview 2017/2018

Summary

The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services.

The Standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in accessible formats.

The Standard also tells organisations how they should make sure that people get support from a communication professional if they need it, and about changing working practices to support effective communication.

Please state any specific needs you have so we can ensure they are identified and accommodated for (these include but are not limited to any sensory impairment, use of an Assistance Dog, physical or mental disabilities, access requirements, religious or cultural needs, translator/interpreter requirement, nutritional requirements and phobias):

Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

- Do you require assistance with communication? **Yes ❑ No ❑**

  Please provide any information that will help us support your needs _____

- Do you need a format other than standard print? **Yes ❑ No ❑**

  Please provide any information that will help us support your needs _____

- Do you have any special communication needs? **Yes ❑ No ❑**

  Please provide any information that will help us support your needs _____

- How do you prefer to be contacted?

  ❑ Home Phone ❑ Mobile Phone ❑ Text
  ❑ Letter ❑ Email

Have you nominated someone to speak on your behalf **Yes ❑ No ❑**

If "yes", please provide their contact information and relationship to you:

Name: _____ Relationship to patient: _____

Address: _____

Phone number: _____

Health Questionnaire

Date of Birth: | D | D | M | M | Y | Y | Y | Y | Surname: _____ First Name: _____

Are you registered disabled?* **No / Yes** If yes please state type of disability_____

Do you have a carer?* **No / Yes** Are you a carer?* **No / Yes**
If yes please complete the Carer Form available from reception

General Medical History

If you are on regular medication, please make an appointment to see a doctor within 2 weeks of registration.
You will not be issued any medication before then.

Serious or Chronic illnesses *(please circle)*

- Blindness
- Glaucoma
- Stroke
- Blood Pressure
- Diabetes
- Heart Attack
- Epilepsy
- Asthma
- Depression
- Cancer

Other serious/chronic illnesses or operations, X-rays or similar tests and when? _____

_____

Height _____ **Weight** _____

What medicines are you taking (*including Warfarin and the contraceptive pill for females*)?_____

_____

Have you any allergies to medicines or anything else? _____

_____

Have you ever smoked? **Yes** / **No** If Yes, are you now an ex smoker? **Yes / No**
If you are an ex smoker, what year did you stop? _____

If you are a smoker, what is your daily consumption?
No of cigarettes _____ Number of Cigars_____ Ounces of pipe tobacco_____

Alcohol Consumption (*please circle*): **T**eetotaller **E**x-Drinker **Tr**ivial drinker (under 1unit a day)
Light Drinker (1-2 units a day) **M**oderate drinker (3-6 units a day) **H**eavy Drinker (7-9 units a day)

Exercise? (*please circle*) **E**xercise Not Possible Enjoys **L**ight Exercise Enjoys **M**oderate Exercise
Enjoys **H**eavy Exercise

Health Questionnaire cont'd

Family History

Serious illness in your close family (***please circle and advise who in your family has had this condition***) *e.g. Diabetes – Maternal / Paternal grandmother*

Illness	Family Member	Illness	Family Member
Blindness		Epilepsy	
Glaucoma		Asthma	
Stroke		Depression	
High Blood Pressure		Cancer	
Diabetes		Sudden Death	
Heart Attack			

Female patients only *please delete as necessary

Have you any children? (*give ages*) _____

Have you had any miscarriages?* **Yes / No** Have you had a termination of pregnancy?* **Yes / No**

Are you pregnant?* **Yes / No** If **Yes**, date of last period? D D M M Y Y Y Y

Have you had a hysterectomy?* **Yes / No** If **Yes**, Date? D D M M Y Y Y Y

What method of contraception do you use at present? _____

When was your last cervical smear test? Result?* Normal / Abnormal

Have you ever had an abnormal smear?* Yes / No

D D M M Y Y Y Y

Date of last mammogram? D D M M Y Y Y Y

Prescriptions

Please advise if you would like us to send your prescriptions via the Electronic Prescription Service (EPS) direct to a local pharmacy.

Select from one of the local pharmacies below:

- ❑ Lloyds – The Avenue, Sunbury
- ❑ Tesco – Sunbury
- ❑ Boots – Sunbury Cross
- ❑ Imagecraft – Nursery Road, Sunbury
- ❑ Trio – High Street, Shepperton
- ❑ Other – please state _____

Practice Use Only:	✓ or ×		✓ or ×
Nominated pharmacy added		EPS set up	
Staff initials		Date	

Declaration

Thank you for completing this form.

By signing below you are signing to register as a patient of Sunbury Health Centre Group Practice.

You are signing to say that the information provided within this form is correct and true to the best of your knowledge and if any details should change, it is the responsibility of the patient (or patient representative) to let the surgery know as soon as possible.

Signature: …….. Date: ……

Delete as necessary: I am the patient or I am signing on behalf of the patient

If you are filling out this form on behalf of another person;
Please ensure that you also fill out the details below.

Patients Name: _____

Patients Date of Birth: _____

Patient Representative Name: _____

Patient Representative Address: _____

_____

_____

Postcode: _____

Please circle one: Parent Legal Guardian Lasting Power of attorney for health and welfare

Please continue overleaf to provide the practice with express consent for ways in which we can communicate with you

Text Communication Consent Form

Patients registering with the practice are able to register for our text messaging service for the purposes of health promotion, practice news and for appointment reminders. Appointment reminders by text are an additional service and the responsibility for attending appointments or cancelling them rests with the patient.

The text message facility can be cancelled at any time by contacting the practice in writing.

Text messages are generated using a secure facility over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

If more than one person shares the use of the mobile phone number detailed below, we will need a consent form from each of those people.

I CONSENT to the practice contacting me by text message for the purpose of health information and appointment reminders. I will ensure that **I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession**

- ❑ Yes
- ❑ No

Patient Name .....

Date of Birth .....

Mobile .....

Signature .....

Date .....

Practice Use Only:	✓ or ×		✓ or ×
SMS consent in EMIS		SMS consent in MJOG	
Staff initials		Date	

Online Access Consent Form

What is Patient Access?

With Patient Access, you can now access our GP services at home, work or on the move— wherever you can connect to the internet (if you are 16 or over). What's more, as Patient Access is a 24 hour online service you can do this in your own time, day or night. Patient Access is also available on a mobile app which is free for iOS and Android users. If you register with Patient Access the following facilities are available to you -

- Book a GP appointment
- View your appointments
- Cancel your appointments
- Order repeat prescriptions and check the progress
- View test results
- View detailed coded medical records

How do I register?

Please select either YES or NO to all of the options below, and we will register your online access.

I would like access to book appointments online YES ❑ NO ❑
I would like access to order repeat prescriptions online YES ❑ NO ❑
I would like access to my test results online YES ❑ NO ❑

I would like access to my detailed coded records YES ❑ NO ❑
If YES – please obtain form (DCRA) from reception and complete as required

Come into the practice with **Photo ID** (passport, driving licence etc) and this form. Once we have processed your registration and checked your details we will supply you with a registration document for you to set up your online account.

Is my information secure?

All information that is sent to our surgery via Patient Access is secure. Your personal details are encrypted and protected using the highest standard internet security, so it cannot be intercepted. Only you and your GP surgery are able to see this information.

Patient Name .....

Date of Birth .....

Signature .....

Date .....

Practice Use Only:	✓ or ×		✓ or ×
Patient access printed		Patient access sent	
Staff initials		Date	

Summary Care Record

YOUR NAME: _____ DATE OF BIRTH: _____

Sunbury Health Centre Group Practice offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Please choose one of the following options:

- ❑ Express consent for medication, allergies, and adverse reactions only
- ❑ Express consent for medication, allergies, and adverse reactions AND additional information
- ❑ Express dissent (opt out) – Patient does NOT want a Summary Care Record

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you are happy for a Summary Care Record to be set up for you then you need take no further action.

Signed_____ Date _____

Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.**

Practice Use Only:	✓ or ×		✓ or ×
SCR set in EMIS		SCR added to consult notes	
Staff initials		Date	