The Cambridge Practice

CONFIDENTIAL MEDICAL REGISTRATION FORM

Personal Details:

Please complete all pages in FULL using BLOCK capitals

Surname:

First Names (in full):

Previous Surnames:

Title: ❒ Mr ❒ Miss ❒ Mrs ❒ Ms ❒ Dr ❒ Male ❒ Female

Date of Birth (day/month/year):

NHS Number: (if known)

Town & Country of Birth:

Address:

Post Code:

Telephone Number:

Mobile Number[1]:

[1] Note, we use the mobile number for text messages.

Email Address[2]:

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

Your previous address in the UK:
For Armed forces please add Address before enlisting:

Post Code:

Name of previous Doctor while at that address:

Surgery Name and Address of previous Doctor:

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP:

Post Code :

If previously resident in UK date of leaving:

Date you first came to the UK:

Where you registered with Armed Forces GP or are you a Armed forces family member

Personal Service number……..

Enlistment Date…… Discharge Date ……..

Are you a Family member of an armed forces personal yes/no

Relationship…….

If you need your doctor to dispense medicines and appliances:

For Dispensing Practices only:

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

Patient Declaration for all patients who are not ordinarily resident in the UK:

Please see appendix 1 for patient declaration (last page of form)

	Name	Contact number	Relationship to patient
Next of Kin details			

Are they registered with the Cambridge Practice ? yes/no

Please circle: Mr/Mrs/Miss/Ms

Personal Medical History:

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please additional inormation use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family Medical History:

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Medical information:

Please provide details of:

	Non Smoker	Ex Smoker	Current Smoker	How many per day
Smoking status:				

	Do you drink Alcohol	Alcohol consumption units per week
Alcohol Status:		

Height	cm
Weight	kg

Women only

When was your last smear test	Date
What was the result	

List of Current Medication:

Name of Medication	Dosage

Please use additional information box at the end of form if you need to add more medication

Allergies:

Please list any allergies you have to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Ethnicity:

❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani
❒ Bangladeshi ❒ Chinese ❒ Other (please state):
❒ Decline to state

Religion:

Please state religion:

Please advise if your religion will affect any treatment received: ❒ Yes ❒ No
If answer is yes please provide more information in additional information box at the end of the form

Language:

Please state your main spoken language:

Does you need an interpreter? ❒ Yes ❒ No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the summary care record on next page.

Where you have provided information on how to contact you, can you confirm you are happy for The Cambridge Practice to contact you by the following?

By email ❒ Yes ❒ No This will be to send you letters, the practice newsletter and the like
By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

Required Information:

Are you looking after someone at home? ❒ Yes ❒ No

If so, who?

What is their relationship to you?

Signatures:

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ❒ Signature of patient ❒

Name of Person Relationship to patient

Additional information:

Summary Care Records :

Summary Care Records	*Tick (only ONE) as Applicable*
1. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions or sensitivities to medications. This summary record will be held on an NHS Central Database and may be used in an emergency when your GP surgery is closed.	
2.* Yes I would like a Summary Care Record with medication, allergies and adverse reactions** ***PLUS additional important information held on my GP record (e.g. Diagnoses – Asthma (lung disease), kidney disease, renal disease, diabetes, epilepsy, cancer etc. and end of life care requests) AND/OR	
I will come and see my GP to discuss any additional information I would like added to my Summary care Record as soon as possible.	
3. No I do not want a Summary Care Record Please be aware that if you choose not to have a Summary Care Record healthcare staff may not have access to important information about you in an emergency but be assured that you will be cared for to the best of their ability.	

Updated 10/06/2020

Appendix 1

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's Details

Please complete in BLOCK CAPITALS and tick ✓as appropriate

❒ Mr ❒ Mrs ❒ Miss ❒ Ms

Surname:

Date of Birth

First Names:

NHS No.

Previous Surname/s:

❒ Male ❒ Female

Town and Country of Birth:

Home Address:	
Postcode:	Telephone No:

SUPPLEMENTARY QUESTIONS

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 ordinary 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 boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ 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

c) ☐ 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:**	DD MM YY
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:
 *If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.*	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
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.

ONLINE RECORD ACCESS ENROLMENT FORM

You can now use the internet to securely view your test results, your medical history, including current and past medication. Whether you want to improve your knowledge of your medical condition, or check your record for accuracy – it's at your fingertips when you need it. You can even access it from anywhere in the world if you need medical treatment on holiday.
By completing this form you are asking us to make information from GP records available to you, securely over the internet. Your information will not be made available without your permission. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

Things to Consider:
Although the chance of the following things happening is very small, please read and tick the boxes to confirm that you have understood:

1. Forgotten History -
There may be something you have forgotten about that could cause distress. ☐

2. Abnormal Results/Bad News -
You may see this before you have spoken to the doctor, or while the surgery is closed and you cannot contact them. ☐

3. Coercion -
If you think you will be pressured into revealing details from within your record to someone else, against your will, please reconsider using this service. ☐

4. Errors in your Record -
In this case please contact the Surgery to enable us to correct your record. ☐

5. NHS App -
Have you downloaded and accessed the NHS app. ☐

PLEASE COMPLETE IN BLOCK CAPITALS

SURNAME	
FIRST NAME	
DATE OF BIRTH	
ADDRESS	
POST CODE	
EMAIL ADDRESS	
TELEPHONE NUMBER	

I wish to access my medical record online and understand and agree with each statement (Please tick)

I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, that is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	

I agree that by completing this form I have read and understood 'Things to Consider' above:

SIGNED			
PRINT NAME		**DATE**	

FOR PRACTICE USE ONLY

Identity Verified (Tick all that apply) ***Vouching*** ☐ ***Vouching with info in record*** ☐ ***Photo ID*** ☐	***Name of Verifier***	***Date***
Name of person authorised to create account		***Date***
Date Account Creation		
Date of Passphrase Sent		