Severnbank Surgery

Tutnalls Street, Lydney,
Gloucestershire GL15 5PF
Tel 01594 845715

This form is new born baby patients only

Patient's details
Mr☐ Mrs☐ Miss☐ Ms ☐
Date of birth……………………. …………..
NHS Number……………………………………..
Town & Country of birth…………….………...
……………………………………………..………

Surname………………………………….…..…
Previous Surname………………..………………
First Names……………………………..……….
(Known as……………………………………….)
☐ Male ☐ Female

Home address……………………………………………………………………………………………..
……………………………………………………. Post Code …………………………………..
Home Telephone number……..……………………..… Work No.……………………….……….
Mobile No: ……………………………………………………………………………………….
Email ……………………………………………………………………………………………
Previous Home Address………………………………………………………………………….
………………………..………………………….. Post Code ……………..……………………
Previous GP Practice…………………………………………………………………………..
I give consent for Severnbank Surgery to contact me via my mobile and agree to notify them of any number change- ☐

If coming from abroad, please tell us your first address in the UK where registered with a GP Practice……………………………………………………………………………………………
………………………………………………………………………………………………………..
Date of first arrival in UK…………………………………..…
Date of leaving if previous UK resident……………………….

Do you need Severnbank Surgery to dispense medication and appliances to you? *please note that not all doctors are authorised to dispense medication*

I live more than 1.6km in a straight line from the nearest chemist ☐
I would have serious difficulty in getting them from a chemist ☐

I consent to the information I have given on this application form being held on file under the terms of the General Data Protection Regulation (GDPR) (EU) 2016/679 and I have attached evidence as proof of identity and permanent address
☐ **Signature of patient** ☐ **Signature on behalf of patient**

Signature…………………………………………………Date of Signature……………………..

Marital Status

Single ☐

Ethnic Group

British/mixed British	☐	Bangladeshi/British Bangladeshi	☐
Irish	☐	Indian / British Indian	☐
Other white background	☐	Other Asian background	☐
Caribbean	☐	Other Black background	☐
African	☐	Other mixed background	☐
Chinese	☐	Other white background	☐
Pakistani & British Pakistani	☐	White & Asian	☐
White & Black African	☐	White & Black Caribbean	☐
Ethnic category not stated	☐	Other: ……………..………………..	☐

First Language …………………………… Other Languages……………………………..

Next of Kin

Name ………………………………………………………………………………………..
Address………………………………………………………………………………………
………………………………………………………………………………………………..
Home Number ………………………………………………………………………………...
Mobile Number ……………………………………………………………………………..
Relationship to you ………………………………………………………………………...
Can we contact your Next of Kin in an emergency? Yes ☐ No ☐
Can we discuss your medical record with you Next of Kin? Yes ☐ No ☐
Is your Next of Kin your main carer? Yes ☐ No ☐

PATIENT INFORMATION SHARING AND CONSENT

All information you give to a member of the practice team is safeguarded by the General Data Protection Regulation (GDPR) (EU) 2016/679 and the NHS Care Record Guarantee. At all times, everyone working for the NHS has a legal duty to keep information about you confidential. However, information is sometimes shared where it is absolutely necessary to support your care or to help improve the service provided by the NHS. **You have a choice about whether your information is shared and for what purpose.** Please tick the boxes below to tell us what your choices are.

Summary Care Record A Summary Care Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.	**Yes- a record will be created for you, but you can opt-out at any time.**	**No- I wish to decline a Summary Care Record.**	
Do you want a Summary Care Record?	**Yes-**	**No-**	

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title .... Surname / Family name ....

Forename(s) ....

Address ....

Postcode.. Phone No .... Date of birth ....

NHS Number (if known)... Signature ....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name .... Your signature.......................................

Relationship to patient .... Date ....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY Add Code 9Ndo

Actioned by practice: yes / no

Date..

Administration Section Only

Allocated/Named GP: …………………… Patient EMIS Number: ……………………

New patient screen offered: Y ☐ N ☐ *NPS offered* ☐ *Declined* ☐

Appointment booked: Date…………………………… Time…………………..

Identity Verified: ……………………………………………………………

Patient Access Request

Patient Requested Online Access- Yes ☐ No ☐

Online Access Request Completed – ☐

Online Access Details Given- Printed ☐ Emailed ☐

Prescription Destination

Previous Prescription Destination removed (if applicable)- ☐

New Prescription Destination added (if applicable)- ☐

I have accepted this patient for general medical services on behalf of the practice ☐

I will dispense medicines/appliances to this patient subject to NHS England approval ☐

Practice Name:

____

Practice Code:

____

Practice Stamp: