ADULTS REGISTRATIONS

Belsize Priory Medical Practice
208 Belsize Road
London NW6 4DX
0207 328 8200

E-mail: reception.bpmp@nhs.net
www.belsizepriorymedicalpractice.co.uk

PLEASE NOTE ALL REGISTRATIONS ARE DONE BETWEEN 2.00PM -6.00PM (Except Wednesday)

We are unable to register you outside these hours as we need to give priority to existing patients

YOU NEED TO BE A RESIDENT IN OUR CATCHMENT AREA

To enable us to process your application as quickly as possible please have the following documents with you. All documents that are required need to be produced prior to appointments being made and your registration.

→ Passport/ Driving Licence (proof of your identification)
→ 2 Utility bills – NO more than 3 MONTH OLD (to prove your address), Tenancy agreement, Council Tax Bill, Landline Bill.
→ NHS NUMBER – Without this we will not be able to register you. Council tax/ tenancy agreement.

A MOBILE TELEPHONE BILL/BANK STATEMENT WILL NOT BE ACCEPTED

Application Forms need to be completed in full.
If you don't understand anything please ask a receptionist who will be pleased to help.

ZERO TOLERANCE

The practice pledges to treat all patients with dignity and respect.
Our staffs have the right to be treated with dignity and respect in the same way.
We will NOT tolerate violence in any form, physical or verbal towards our staff.

APPOINTMENT BOOKING ONLINE

You can book and cancel your appointment, request prescription and update your address ONLINE via The Practice website: www.belsizepriorymedicalpractice.co.uk.

Please request your PIN Number from the Receptionist during your Registration.

Office use only 2 proofs of address ☐ Leaflet given ☐ **CIDR opt out form given**

ID ☐ Surgery pod ☐

Checked by: _____ Registered by: _____ Date: _____ Emis: _____

MR ☐ Mrs ☐ Miss ☐ Ms ☐	NHS NUMBER:
Surname's	
First Name's	
Previous Surname/s	
Date of Birth	
Place of Birth	
Home Address	
Telephone Number	
Email Address	
Appointment Online	
Occupation	
Personal States e.g Single/Married	
Next of Kin	
Relationship	
Telephone Number	

Ethnic Category:

White	Mixed	Asian and British Asian	Black/British Black	Other
British	White and Black Caribbean	Indian	Caribbean	Chinese
Irish	White and Black African	Pakistani	African	Other
Other Please State Below	White and Asian	Bangladeshi	Other Please state below	
	Other Mix	Other		

Main Language: _____

Interpreter: Yes ☐ **No** ☐

Height:	
Weight:	

Religion: _____

Allergies: _____

Smoking Status:

Never Smoked ☐ **Current Smoker** ☐ **Ex-Smoker & what year you quit** ☐ _____

How many do you smoke a day? _____

How many years have you smoked for? _____

Do you want help in quitting smoking: Yes ☐ No ☐

Family History: (Tick and Please state family member)

Cancer	High Blood Pressure	Epilepsy
Stroke	Diabetes	Mental Health Problems
Heart Disease	Asthma	Eczema
Bronchitis/ Emphysema	Thrombosis	Hypertensive

Have you been diagnosed with any of the above or had any operations? _____

_____

Alcohol Consumption:

Questions	0	1	2	3	4	**Your score**
How often do you have a drink containing alcohol	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking ?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more for male on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or most days	
					Final Score	

Exercise and Activity

How many times a week do you exercise:

Never ☐ Once a week ☐ 2-3 times a week ☐ 3 or more times a week ☐

What type of exercise do you do: _____

Blood Pressure Reading: ☐ ☐ ☐

If you are over 25 and are female please give the following information of your last smear test:

Date	Result	Place

If you have had a mammography test, please give the following information:

Date	Result	Place

Patient Name:	Patient Signature:

Current Medications:

Are you on any medication? _____

I live more than 1 mile in a straight line from the nearest chemist: Yes ☐ No ☐

I would have serious difficulty in getting them from a chemist: Yes ☐ No ☐

Office use only
code:**9QA**

COLLECTION OF PRESCRIPTIONS

With effect from 09/10/2009, any patient wishing for someone else to collect their prescription will have to give the Practice a signed consent. Reception staff will not be able to hand a prescription over to anyone collection on someone's behalf without prior consent.
Please complete the appropriate box:

☐ I give consent for _____ to collect prescriptions on my behalf.

☐ I do not give consent for any 3rd party to collect prescriptions on my behalf.

☐ No applicable
This consent is to remain in force until further notice of cancellation by me.

Signed: _____ Print Full Name: _____

N.B. We are unable to hand out prescriptions to anyone under the age of 15 on someone else's behalf.

Leaving Messages by voicemail/Text

Office use only:
code **9ndi**

In accordance with the Data Protection Act, The practice needs consent from any patient that has an answer phone and is happy for us to leave a message. If we do not have consent, we will be unable to leave messages on an answer phone or with a 3rd party.

Please complete the appropriate box:
☐ I give consent for the Practice to leave message on the answer phone.

Telephone number: _____ and/ or _____

☐ I do not give consent for the Practice to leave messages on my answer phone

☐ I give consent for the Practice to leave a message about my aspect of my medical treatment with _____

This consent is to remain in force until further notice of cancellation by me.
Signed: _____Print Full Name: _____

To be completed if you have specific communication needs:

Communication Support

If you struggle to complete this form, please ask a member of staff to help you.

Do you consent for this information to be shared with other health & social care organisations?
Yes [ ] No [ ]

Do you need an interpreter? Yes [ ] No [ ] Language:……

Are you visual Impaired? Yes [ ] No [ ]

Deafness: Yes [ ] No [ ]

Do you need large print/Easy to read format? Yes ☐ No ☐

Do you use hearing aid? Yes ☐ No ☐

Do you communicate in British sign language? Yes ☐ No ☐

Would you benefit from any of the following: Braille [ ] Large Print [ ] Audio tape [ ]
(please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Other……

If you have a difficulty communicating, which is your preferred method of communication.

Home tel number	[ ]	letter to home address	[ ]
Work tel number	[ ]	letter to temporary address	[ ]
Mobile tel number	[ ]	Fax	[ ]
Email address	[ ]	video conference*	[ ]

(*please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Do you have any other communication need we should know about? Please Describe?

Name……

Date of Birth:……/……/……

Please note: The information you give will be treated confidentially and is subject to the Data Protection Act.

Your emergency care summary

What is the Summary Care Record?

It is NHS centrally held electronic record which contains:

- Your recent and current **Medication** (from last 12 months)
- **Allergies** you suffer from
- Any **Adverse Reactions to Medicines** you have had.

Why do I need a Summary Care Record?

Summary Care Records are being introduced to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record, it will give healthcare staff faster, easier access to essential information about you, and help to give you safe treatment during an emergency, when admitted to hospital or when your GP surgery is closed.

For example, a person who lives in London is on holiday in Brighton. One evening, they're knocked unconscious in a car accident and taken to an accident and emergency (A&E) department. Under the current system of storing health records, it would be difficult for A&E staff to find out whether there are any important factors to consider when treating the person (such as any serious allergies to medications), especially as their GP surgery is likely to be closed. If healthcare staff cannot get the relevant health information quickly, some patients may be at risk.

A Summary Care Record is an electronic record that's stored at a central location. As the name suggests, the record will not contain any other information about your medical history. It will only contain: your last 12 months medication, your allergies and adverse reactions to medicines.

Who can see it?

Access to your Summary Care Record will be strictly controlled. The only people who can see the information will be healthcare staff directly involved in your care who have a special smartcard and access number (like a chip-and-pin credit card).

Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, e.g. because you're unconscious, healthcare staff may look at your record without asking you. If they have to do this, a record will be made.

How do I know if I have one?

Summary Care Records are now in Camden and all patients will have a summary care record created, and it will include just their medications (last 12m), allergies and adverse reactions to medicines.

Do I have to have one?

No, if you choose not to have one, then you will need to complete a form and bring it along to the surgery. You can download a form, or obtain one from your surgery. You can change your mind at any time – just tell your Practice.

More Information For further information visit www.nhscarerecords.nhs.uk or call the information line on 0300 123 3020

DATA SHARING

Please read and make your selection by ticking the box or boxes next to the right statment please fill out the required information below, sign and date the form and return it to reception.

Recording Consent of New Patients for Data Sharing Initiatives in Camden		
Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care. **PLEASE READ ATTACHED INFO**	I want to: Opt in to CIDR. ☐ Opt out of CIDR. ☐ **IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM ATTACHED.** **ADMIN- do not code opt put.**
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐

Name: .....

Date of Birth: .....

Signature: ..... **Date:** .....

PLEASE SIGN CIDR OPT OUT FORM, attached, IF YOU OPT OUT OF CIDR

Belsize Priory Medical Practice

Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, Belsize Priory Medical Practice would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting [insert name].

Please complete this form and hand it in at the practice reception
if you consent to any, or all, of the above.

Patient Name _____ **Date of Birth** **……./……./…….**

Mobile _____ **Consent to use?** **Y** **N**

Email _____ **Consent to use?** **Y** **N**

_____

_____

Signature _____ **Date** _____

Please confirm your consent to one (or more) of the following;

☐ **Newsletters (and similar communications)**

☐ **[Add Additional Activities carried out via text or email]**

☐ **[Add Additional Activities carried out via text or email]**

You can grant consent to all the purposes of use, one of them or none of them.
Where a patient does not grant consent then the Practice will not be able to use their personal data.

Application for online access to book appointments, request medications and access my medical record

Surname	Date of birth
First name	
AddresPostcode	
Email address	
Telephone number	Mobile number

☐ **I consent to receiving my activation PIN via email and confirm the above email is correct**

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation	