Patient Registration Form

Welcome to Dr Laliwala and Partners. We are delighted that you have chosen us to help you manage your health and wellbeing. The information contained within the form is important to enable us to provide you with the highest level of care. Please complete as much as you can.

NAME	
DATE OF BIRTH	
EMAIL ADDRESS	
HAVE YOU BEEN REGISTERED HERE BEFORE?	YES / NO
SMOKING STATUS	Never Smoked/ Ex-smoker/ Current Smoker
WOULD YOU LIKE HELP TO STOP SMOKING	YES / NO
DO YOU DRINK ALCOHOL	YES / NO
IF YES, HOW MANY UNITS DO YOU DRINK PER WEEK	
ARE YOU A CARER?	YES / NO
IF YES, WHO DO YOU LOOK AFTER?	
ETHNICITY	
MAIN LANGUAGE SPOKEN	
DO YOU REQUIRE AN INTERPRETER?	YES / NO
DO YOU HAVE ANY NEEDS? COMMUNICATION, DISABILITY, MEMORY ETC	YES / NO Please specify:
HAVE YOU SERVED IN THE ARMED FORCES, IF SO, DO YOU HAVE A SERVICE OR PERSONNEL NUMBER?	
ONLINE SERVICES – would you like access to the online service?	YES / NO

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NAME		**Relationship to you**	
ADDRESS		**Telephone Number**	

The choices you would like to make about sharing your health record

Sharing Out

I would like my health record at this practice or service to be shared with other healthcare services providing care for me ☐ Yes ☐ No

Sharing In

I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services ☐ Yes ☐ No

My choices apply to my record here at Dr Laliwala and Partners

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

Please complete in BLOCK CAPITALS

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

Forename(s) .....

Address .....

.....

Postcode ..... Phone No .....

Date of birth .....

NHS Number (if known) .....

Signature .....

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
CONFIDENTIAL
Ref: 4705

NHS Summary Care Record with additional information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

You can choose to have additional information included in your SCR, which can enhance the care you receive. This information includes:

- Your illnesses and health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated - such as where you would prefer to receive care
- What support you might need
- Who should be contacted for more information about you

What to do next

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form, for return to the relevant GP surgery.

Name of Patient: ……

Date of Birth: …… Patient's Postcode: ……

Surgery Name: …… Surgery Location (Town): ……

NHS Number (if known): ……

Signature: …… Date: ……

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; **you** sign the form above and provide your details below:

Name:……

Capacity:	Parent	Legal Guardian	Lasting power of attorney or health and welfare

If you require any more information, please visit www.hscic.gov.uk/scr/patient phone HSCIC on 0300 303 5678 or speak to your GP practice.

For practice use: To update the patient's consent status to 'Express consent for medication, allergies, adverse reactions and Additional Information' use the SCR consent preference dialogue box or add Read code **9Ndn** (or CTV3 code **XaXbZ** for SystmOne practices).

MEMO

TO: Child Health
Winchester Place

FROM: Dr Laliwala & Partners

DATE:

Subject: New patient registration- children under 19 years

MOTHER OR FATHER	**NAME:**	
	DATE OF BIRTH: **NHS No:**	
	ADDRESS:	
	TELEPHONE NUMBER:	

CHILDREN:	**NAME:** **NHS No:**		**Date of Birth:**	
	NAME: **NHS No:**		**Date of Birth:**	
	NAME: **NHS No:**		**Date of Birth:**	

LANGUAGE **Please specify:**	
INTERPRETER REQUIRED:	**YES/NO**

SCHOOL NAME: