Combe Down Surgery

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname:

First Names (in full):

Title: ☐ Mr ☐ Miss ☐ Master ☐ Other: ☐ Male ☐ Female

Date of Birth (day/month/year): NHS Number:

Town & country of birth:

Address:

Post Code:

Telephone number: Mobile number:

Email address:

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

Your previous address in UK:

Post Code:

Name of previous Doctor while at that address:

Address of previous Doctor:

Post Code:

If you are from abroad:

Previous address abroad:

Country:

If previously resident in UK, date of leaving:

Date you first came to UK:

If registering a child under 5 years old:

☐ I wish the child above to be registered with Combe Down Surgery for Child Health Surveillance

I would like to collect my prescription from:

☐ Lloyds Combe Down ☐ Lloyds Odd Down ☐ Dudley Taylor ☐ Wellsway Pharmacy

☐ Other:

NHS Organ and Blood Donor registration:

Children can be included on the Organ Donor or Blood Donor register. Children can make this decision themselves if they feel able to do so and have a clear understanding of what this means, however if under 18 at the time of potential organ donation then parental consent will still be sought. Parents may register their children and sign on their behalf.

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 ☐

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply:

☐ Any of my organs and tissue, or
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas

Signed: Date:

Relationship to child if not signed by patient:

For more *information please ask at reception for an information leaflet or visit the website: www.uktransplant.org.uk or call 0300 123 23 23*

Personal Medical History:

Type of Birth, if under 5:
(eg normal, forceps, caesarean)

Birth Weight, if under 5:

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Allergies:

Name of medication or allergen:	What was the problem or upset?

Immunisations:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

Family History:

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

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

If appropriate, please give further information (eg, age of diagnosis, type of Cancer, etc):

List of current medication:

Please attach a copy of any repeat medications, or ask reception to make a copy when registering.

Please note: Repeat medications will not be continued until reviewed by a doctor. If you have any medications that will need reissuing in the next 2 weeks you must inform reception, otherwise there will be a delay in collecting this medication.

Name of medication:	Dosage: (strength, and how often)

Ethnicity:

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Chinese
☐ Romanian ☐ Polish ☐ Other (please state):
☐ Decline to state

Next of kin:

Name:

Telephone number:

Relationship:

Data sharing consent choices:

To ensure you receive the best continuity of care, we upload certain medical information so that it is available to other healthcare organisations (eg. Emergency Departments or Out-of-Hours doctors). Should you wish to know more about how and what type of information is shared and what your options are regarding the sharing of any information, please ask at reception for a 'Data Sharing' information leaflet. Please be aware that we will assume you consent to share your patient data unless you instruct us otherwise.
If you wish to **OPT OUT** please complete the form at the end of the leaflet and give to reception.

Online Services Information:

You can book GP appointments and request repeat prescriptions online. You will need to obtain a log-on code and password from Reception. For your own security you must bring photographic ID. You must be registered before you switch to online medication requests.

Contact via text and email:

Where you have provided information on how to contact you, can you confirm you are happy for Combe Down Surgery to contact you by the following:

By email ☐ Yes ☐ No
By text ☐ Yes ☐ No

Communication / information needs:

Do you have any communication / information needs relating to a disability or sensory loss and if so what are they?

Would you be happy for us to share your communication/information needs as part of our existing data sharing processes? ☐ Yes ☐ No

Signature:

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

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐

For internal use only:

2 items of ID seen: Photo ☐ Address ☐

Seen by (initials): Date:

Updated 07/04/17