

New Patient Check Appt ..... EMIS No:.....

**'NEW PATIENT HEALTH QUESTIONNAIRE**

Surname: ..... Forename(s): .....

Date of Birth: ..... Mobile Number: .....

Email address: .....

You will be automatically registered to receive messages by email, mobile phone & SMS text message. If you would like to opt out please inform reception. It is your responsibility to let the practice know if you have a change in phone number or email address.

If you are of school age, are you home schooled? YES / NO

Do you have any information and / or communication support needs e.g. interpreter, information or letters in larger type or use braille. YES NO (delete as appropriate)

If "Yes" please let us know what support you need

.....  
.....

Date of completion of this form: .....

**ALLERGIES**

Are you allergic to any substances or foods? Yes / No

If yes, please give details:

.....  
.....

***Thank you for completing this questionnaire.***

**PATIENT ETHNIC ORIGIN QUESTIONNAIRE**

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

**A White**

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please write in below

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**B Mixed**

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please write below

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**C Asian or Asian British**

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please write below

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**D Black or Black British**

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	
<input type="checkbox"/>	Any other black background please write below

**E Chinese or other ethnic group**

<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other please write below

Declined	
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<b>First language</b>
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### Information for new patients: about your Summary Care Record

#### Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. 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 a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

#### You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that 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 and who should be contacted for more information about you.
- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose one of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

Express consent for medication, allergies and adverse reactions only.

or

Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

Express dissent for Summary Care Record (opt out).

Name of Patient: .....

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

Surgery Name: Danby Surgery          Surgery Location: Briar Hill, Danby, Whitby, North Yorkshire, YO21 2PA

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: .....

Please circle one: Parent Legal Guardian Lasting power of attorney  
for health and welfare

If you require any more information, please visit <http://systems.digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP Practice.