The Key Medical Practice
Exeter Close
Kidlington
Oxon
OX5 1AP

Partners: Dr Sarah Morris, Dr David Finnigan, Dr Dawn Leedham, Dr Elamathi Prabhakaran, Dr Judith Graham, Dr Simon Tucker

Registration for Children Under 5

(Necessary information will be passed on to the Health Visitors)

First name:	Last name:
Address:	
	Postcode:
Date of birth:	
Previous Address:	
	Postcode:
Previous GP Surgery:	

Parent/Guardian name:		
Address:		
	Postcode:	
Date of birth:		
Telephone numbers		
Home:	Mobile:	Work:
Previous Address:		
	Postcode:	
Previous GP Surgery:		

Routine Childhood Immunisations (found in red book)	Age Usually Given	Date Given	Declined (yes/no)
1st DTP/Hib/Polio	2 months		
Pneumococcal			
2nd DTP/Hib/Polio	3 months		
Men C			
3rd DTP/Hib/Polio	4 months		
Men C			
2nd Pneumococcal			
Hib/Men C	Around 12 months		
1st MMR	Around 13 months		
Booster Pneumococcal			
2nd MMR	3 years 4 months approx.		
4th DTP/Hib/Polio(pre school booster)			
Human Papillomavirus Vaccine	Females only 12 – 13 years	1st / 2nd / 3rd	
5th DTP/Hib/Polio(school leavers booster)	13 – 18 years		

Ethnicity - Information about your ethnic background allows us to make sure our services reflect the needs of everyone in our patient population.

Please complete the following on behalf of your child:

Ethnic category 2001 census					
British White	□	British Asian	□	British Black	□
Other Mixed British	□	Polish	□	Other European	□
Asian	□	African	□	Americas	□
Other White Background	□	Other Mixed Background	□	Any Other	□
Prefer not to say	□				

ELECTRONIC PRESCRIPTION SERVICE

We offer an electronic prescribing service. This means your scripts are sent via computer to your nominated pharmacy.

Would you like to use this service? YES or NO

If yes, please nominate a pharmacy:

Name of pharmacy:	
Address:	Postcode:

Practice Area

Although we accept patients who live outside of our practice area, we do not provide visits for these patients if they become too unwell to visit the practice. If these patients do require a visit, an available local GP can be found by calling 111. For patients with complex conditions, it may be more appropriate to register with a GP closer to home; these patients will notified by letter.

I understand that if I live outside the practice area as shown in the practice leaflet,

I will not be eligible for home visits. Signed:

……

Information sharing

Summary Care Record and Oxfordshire Care Summary

Please note that these records are ***NOT CONNECTED*** with the Health and Social Care Information Centre (HSCIC) single database care data project, and will be used ***only*** for the purpose of enabling informed care to be supplied directly to you as an individual.

Your patient record is held securely and confidentially on the electronic system in our practice. If you require treatment in another NHS healthcare setting such as an Emergency Department, those treating you would be better able to give you appropriate care if some of the information from the records we hold were available to them.
This information can now be shared electronically via:

1. **The Summary Care Record (SCR)** used nationally across England

2. **The Oxfordshire Care Summary (OCS)** used locally across Oxfordshire

In both cases, the information will be used **by authorised health care professionals directly involved in your care only**. Your permission will be asked before the information is accessed, unless the clinician is unable to ask you and there is a clinical reason for access.

The Partners of The Key Medical Practice recommend that patients consent to sharing their medical information with OCS as it will enable them to access developing services within the county

A parent or guardian can request to opt out children under 16 but ultimately it is the GP's decision whether to create the records or not, because of their duty of care to the child. If you are the parent or guardian of a child under 16 and feel that they are able to understand, then you should make this information available to them.
More information about the information held in these two records is available at reception and on our website.

It is very important to answer the questions below as we cannot make a decision for you. Without your direction, we cannot guarantee that your wishes will be met, even if you have previously made a similar choice in another practice.

	SCR	OCS
I give consent for information about my medications, allergies and adverse reactions to be shared	**Yes / No**	**Yes / No**
I give consent for information about my medication, allergies, adverse reactions and other information (see below) to be shared	**Yes / No**	**N/A**

Other information = Your long term health conditions, your relevant medical history, your health care preferences, your immunisations.

NHS England's Care Data – Registering and Objection

NHS England's care data system aims to provide timely, accurate information to citizens, clinicians and commissioners about the treatments and care provided by the NHS. \

Please refer to the NHS England's care data patient information leaflet before completing this form.

The NHS England's care data patient information leaflet can be found in our surgery waiting room; on our website (www.kidlingtonandyarntonsurgery.co.uk) or on the NHS England website (www.england.nhs.uk/ourwork/tsd/care-data/).

If you do not want information that identifies you to be shared outside your GP practice, you can ask your practice to make a note of this in your medical record. This is called an objection. An objection will prevent your confidential information being used other than where there are exceptional circumstances or where the law allows your information to be shared.

OBJECTION FORM – Confidential

☐ **Please tick this box** if you **do not** want any information containing data that identifies you from leaving your GP practice. This type of objection will prevent the identifiable information held in your GP record from being sent to the HSCIC secure environment. It will also prevent those who have gained special legal approval from using your health information for research. The surgery will block the uploading of your identifiable and personal information to the HSCIC.

☐ **Please tick this box** if you **do not** want information containing data that identifies you from leaving the HSCIC secure environment. This includes information from all places you receive NHS care, such as hospitals. If you object, confidential information will not leave the HSCIC and be used in this way, except in very rare circumstances for example in the event of a civil emergency. The surgery will code your record which will alert the HSCIC not to use your information in this way.

If you wish to cancel this at any time in the future please let reception know.

A. Please complete in BLOCK CAPITALS

Title: _____ Surname: _____

Forename: _____ Date of Birth: _____

Address: _____

Postcode: _____ Phone No: _____

Signature: _____ Date: _____

B. If you are filling out this form on behalf of another person or a child, please ensure that you fill out their details in section C and your details in section D.

Your Name: _____

Your Signature: _____ Date: _____

Relationship to Patient: _____

Please return this form to reception and your records will be coded accordingly.

NEXT OF KIN FORM

Please complete this form with details of the person that we should contact should we not be able to get in touch with you directly. It may be a family member, a neighbour, a friend or a carer.

Your name:		**Date of birth:**	

How is your next of kin related to you? *(e.g. my son, my daughter, my friend, my neighbour, my carer)*	

Details of your next of kin:

First Name:		**Surname:**	
Date of Birth:			

Address:	

Telephone numbers		
Home:	**Mobile:**	**Work:**

Is your next of kin a patient at The Key Medical Practice?	**YES or NO**
Should we contact this person in an emergency regarding your medical care?	**YES or NO**
Do you give permission for us to discuss your medical record with this person?	**YES or NO**
Is this person a carer for you?	**YES or NO**
Is this person your MAIN carer?	**YES or NO**

Signed:	
Date:	

PATIENT CARE – TEXT MESSAGING

Declaration

I consent to the practice contacting me by text message for the purpose of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all or on any occasions, and that the responsibility of attending appointments or cancelling them rests with me.

I can cancel the text messaging service at any time.

The surgery does not offer a reply facility to enable patients to respond to texts directly.

Text messages are generated using a secure facility.

The practice will not transmit any information which would enable an individual patient to be identified. However, I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure.

Patient Name…….

Date of Birth……

Mobile Phone Number……..

Patient Signature…… Date…….

For surgery use – Emis No:_____