Westside Medical Centre Data sharing "Opt Out" form.

I confirm that I know enough about the various data extractions in place or proposed. Please block data extraction from the patient whose details appear below. I specify the precise areas I wish to block below:

Title of patient	
Surname of patient	
Forename of patient	
Address	
Phone No. (Mobile if possible)	
Date of Birth.	
Patient's Signature (unless a child aged under 18)	
Date	

If completing this on behalf of a child, please also complete below:

Your name (BLOCK CAPITALS)	
Your signature:	
Your relationship to the patient	

Please tick any or all of the 4 areas detailed below that you wish to prohibit data extraction to: If you do not complete this section you will NOT be opted out from data extraction

Area involved	Tick those from which you wish to **prohibit** use of your data	*Practice use only*
1. Summary Care Record (SCR)		*9Ndo*
2. National "Care.Data" scheme		*9Nu0*
3. Use of your data from other sources: (A&E, Hospitals etc)		*9Nu4*
4. Any local (e.g. CCG) Care Record		*93C1*

PLEASE RETURN THIS FORM TO PRACTICE RECEPTION:

Or Email it to the following practice address: westsidemedicalcentre@nhs.net

Westside Medical Centre

Please FULLY complete this questionnaire to ensure we have as much information about your health to update our records, incomplete application forms will not be accepted. If you are taking any regular medication please attach a copy of your repeat medication list to this application form (this can be obtained from your current surgery), if this is not possible, please bring your medication boxes with you when you hand in this completed application form.

Personal Details *(PLEASE PRINT CLEARLY)*

Forename(s): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐

Telephone Number(s):

Home ☐☐☐☐☐-☐☐☐☐☐☐ Mobile ☐☐☐☐☐-☐☐☐☐☐☐

Next of Kin

Title & Full Name:……

Relation to Person……

Emergency Contact Number: …….

In case of emergency, do you give permission for your medical records to be discussed with this person? YES/NO

Text Messaging Service

This Surgery offers a text reminder service to remind you of appointments you have booked. Do you wish to join this service? YES/NO (If you say yes, we will send reminders to the number you have given above).

(PLEASE NOTE IT IS YOUR RESPONSIBILITY TO NOTIFY THE SURGERY OF ANY CHANGES TO YOUR CONTACT NUMBERS)

Carers

Are you cared for by someone either on a Full or Part time basis?

If yes, please specify name and contact number……..

Do you care for someone either on a Full or Part time basis?

If yes, please specify name and contact number……..

Health Information

Do you smoke? YES/NO

If yes, how many per day? ……

If no, have you ever smoked? If yes, when did you quit and how many did you smoke per day?
……...

Do you drink alcohol occasionally? YES/NO Do you drink alcohol regularly? YES/NO

How many units per week?..... (UNITS – 1 Pint – 2, 1 small glass of wine – 1, 1 measure of spirits – 1)

Medical History

Do **YOU** suffer with any of the following medical conditions?

ASTHMA □ ANGINA □ STROKE □ HEART ATTACK □

GLAUCOMA □ DIABETES □

Do **YOU** suffer with any other medical conditions? YES / NO
DETAILS ……

Do **YOU** have any allergies? YES / NO
DETAILS……

Family History

Is there any family history of the above medical conditions ? (i.e. Parents / Siblings / Grandparents / Aunts / Uncles?) YES / NO

DETAILS ……..

……

Ethnic Origin

Westside Medical Centre Equal Opportunity Policy

Westside Medical does not discriminate.

We have a policy to ensure no patient receives less favourable treatment on the grounds of sex, disability, marital status, colour, race or ethnic origin, age, religion, religious belief, sexual orientation, gender reassignment or is disadvantaged by conditions or requirements which cannot be shown by us to be justifiable.

We are committed to an ongoing programme of action to make this policy fully effective. To ensure this policy if fairly and fully implemented and monitored and for no other reason, would you please complete the information below.

Main Spoken Language:……

2nd Spoken Language:……

I would describe my ethnic origin as:

WHITE

- □ British or mixed British
- □ English
- □ Irish
- □ Scottish
- Welsh
- European(which)……
- □ Any other White background

ASIAN

- □ Bangladeshi
- □ Indian
- □ Pakistani
- □ Any other Asian background

CHINESE

- □ Any Chinese background

MIXED ETHINC BACKGROUND

- □ Asian/White
- □ Black African/White
- □ Black Caribbean/White
- □ Any other mixed background

BLACK

- □ African
- □ Caribbean
- □ Any other Black Background

ANY OTHER ETHNIC GROUPS

ETHNIC GROUP NOT STATED

Patient Consent

- When it is your turn to see the Doctor/Nurse your name will be displayed on the information board above the information the reception desk.
- There will be times when a Doctor/Nurse needs to examine you physically – if you require a chaperone, please ask.

I have read and understood everything in this questionnaire and agree to be examined.

Signed …….. Dated ……...

Health Visitor and School Nursing Liaison

If you have any children aged between 0 and 16 years, please complete this form. This information will be shared with the health visitor (for pre-school children) or the school nursing team (if school age).
Please list children who are registered/registering.

Parent(s) Details

Name:……

Address:……
……..
…… Post Code…….

Telephone Number(s) ……..

Children(s) Details **Please list only the children who are registered/registering with this practice**

Please note: we will need the immunisation record for all patients under 16 years – please bring with you to Surgery either your child's red book(s) or a printout of immunisations from your current GP Surgery.

Child 1…… Date of Birth ……..

If school age, name of school …….

Child 2…… Date of Birth ……...

If school age, name of school …….

Child 3…… Date of Birth ……...

If school age, name of school …….

Child 4…… Date of Birth ……...

If school age, name of school …….

GP Details

Registering with G.P (to be completed by Staff) ……

Surgery Details

Westside Medical Centre, Hilton House, Corporation Street, Rugby, Warwickshire, CV21 2DN
Tel: 01788 544744 Fax:01788 563141