Dr T Abela & Partners
Chafford Hundred Medical Centre

REGISTRATION FORM

Registration times for identification paperwork

Mornings	Monday - Friday	9.00am - 12.00pm
Afternoons	Monday - Wednesday	2.00pm - 5.00pm
	Friday	2.00pm - 5.00pm

Identification paperwork required

Please provide Copies as we are unable to return original document's

Adults

- Utility Bill or Bank Statement dated within the last 3 months, with your name and address included.
- Passport (and Visa if applicable) or Birth Certificate if born in UK.

Children

- Passport (and Visa if applicable) or Birth Certificate if born in the UK.
- Child's Red Book or immunisation records where possible.

Welcome to Chafford Hundred Medical Centre

Patient Data

It is important to let us know of any changes to your details so that your records are kept up to date.

NAME: ……

DATE OF BIRTH: ……

MOBILE TEL: ……

HOME TEL: ……

On occasion your mobile telephone number may be used to remind you (by text) of future medical reviews and/or appointments and possibly test results.

We would appreciate it if you would indicate your consent/dissent below.

I confirm that **I do / do not** consent to receiving text messages from the Practice.

Signed _____

PATIENT CONSENT FOR EMAIL COMMUNICATION

I understand that I choose to make use of the email communication service with Dr T Abela & Partners.

I confirm that I have been given a copy of the Emailing Patient's Leaflet explaining how the email communication works.

I have read this policy and will comply with the patient requirements. I understand that email is not a secure medium. I understand that my emails and responses could be intercepted and read by someone else.

I understand that it is my responsibility to check my emails and notify the surgery of any changes.

I understand that if I require clinical advice I must contact my GP by telephone or by attending the surgery.

My email address for communication is:-

……..…
This email is shared ☐ This email is not shared ☐

Signed _____

Changes To Your Health Records

We (the NHS in England) are changing the way we store and manage your health records.

Please read the Summary Care Records leaflet carefully. It will give you information about new Summary Care Records (SCRs)

I confirm I have received information relating to the NHS Summary Care Record. ☐

NHS Organ Donor Register

The NHS Organ Donor Register records the details of people who have registered their wishes to be an organ and/or tissue donor after their death. To join the NHS Organ Donor Register please ask for a leaflet - let those closest to you know your wishes about organ donation.

Are You A Carer?

Do you look after someone who is ill, frail, disabled or mentally ill?
If so, you are a Carer and we would like to support you. Please ask the Receptionist for a Carers Identification & Referral Form to complete.

Electronic Prescription Service

The Electronic Prescription Service (EPS) is an NHS Service which allows us to send your prescriptions electronically to a pharmacy of your choice (near to where you live, work or shop). This allows you to collect your repeat prescription direct from your regular collection point without returning each time to your GP surgery to pick up your paper prescription. If you wish to nominate a place for us to electronically send your prescription please speak to any pharmacy or dispensing appliance contractor that offers EPS or someone at the surgery to add your nomination to your records for you. You do not need a computer to use this service. Please remember to let us know of any changes.

Your Nominated Pharmacy _____

We would also appreciate you indicating your relationship status and first language.

Please tick one box on each of the following pages

Single person	
Married	
Common law partnership	
Separated	
Divorced	
Widowed	
Marital State unknown	

Language		Language	
Akan (Ashanti)		Lingala	
Albanian		Luganda	
Amharic		Makaton (sign language)	
Arabic		Malayalam	
Bengail & Sylheti		Mandarin	
Brawa & Somali		Norwegian	
British Signing Language		Pashto (Pushtoo)	
Cantonese		Patois	
Cantonese and Vietnamese		Polish	
Creole		Portuguese	
Dutch		Punjabi	
English		Russian	
Ethiopian		Serbian / Croatian	
Farsi (Persian)		Sinhala	
Finnish		Somali	
Flemish		Spanish	
French		Swahili	
French Creole		Spanish	
Gaelic		Sylheti	
German		Tagalog (Filipino)	
Greek		Tamil	
Gujarati		Thai	
Hakka		Tigrinya	
Hausa		Turkish	
Hebrew		Urdu	
Hindi		Vietnamese	
Igbo (Ibo)		Welsh	
Italian		Yoruba	
Japanese		Other	
Korean			
Kurdish			

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 on the next page.

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** category and then tick **ONE** box to indicate your background.

I hereby declare that, I …… …….. have declined to complete the section relating to my ethnicity.

Signed……

Patient Ethnic Origin Questionnaire

Category		Description
White		British
		Irish
		Any other White background
Mixed		White and Black Caribbean
		White and Black African
		White and Asian
		Any other mixed background
Asian or Asian		Indian
		Pakistani
		Bangladeshi
		Any other Asian background
Black or Black		Caribbean
		African
		Any other Black background
Other Ethnic		Chinese
		Any other ethnic group
		Not stated

Please complete this page for children under 16 years only

Family Details	
Parent's full name: DOB:	Parent's full name: DOB:
Names & DOB of siblings:	
Name and relationship to child of any other household members:	
Address of mother/father* (if different from child's) : **delete as appropriate*	

Families Receiving Additional Support		
Does your child have a social worker? (If yes, please give their name, address and contact number)	Yes ☐	No ☐
Is the child in a care home or fostered?	Yes ☐	No ☐
Who has Parental Responsibility?		

Signature: _____ Date: _____

PATIENT AGREEMENT

On joining this Practice please note the following expectations:

You must be prepared to see the Nurse Practitioner, Practice Nurse of other healthcare professional instead of a Doctor for minor illnesses or other appropriate conditions. They are an essential part of our patient care team, helping to free up a Doctor's time for patients with more complex problems.
In order to make the best use of a clinician's time you may be asked some questions when you are making the appointment. This is so we can offer you a consultation with the most appropriate person to deal with your condition.

Please do not shout at our receptionists who always aim to do their best for all patients, whilst following guidelines set by the Practice. The receptionists will be as helpful as possible, but can only offer you the services available at that time.
There appears to have been an increase in abusive behaviour and as such this Practice operates a "zero tolerance" approach for rude, aggressive and abusive behaviour on the surgery premises which includes personal, abusive and aggressive comments, cursing/swearing, physical contact, threats and aggressive gestures. Patients who persist in behaving in a way which upsets staff or other patients will be removed from the Practice list.

If you cannot attend your appointments for any reason please let us know as soon as possible. This will enable us to offer the appointment to someone else.
Due to an increase in the number of wasted appointments through patients failing to attend without informing the surgery it has become necessary to enforce the policy of possible removal from the Practice List if you fail to attend 3 appointments over a 12 month period.
If you fail to attend two appointments over a 12 month period the Practice will write to you asking if there are any specific problems preventing you from letting us know. If you fail to attend for a 3rd appointment this will result in possible removal from the Practice list.

PRINT NAME: ……

SIGNED: ……

DATE: ……