NHS Digital

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: ..... Surgery location (Town): .....

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

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6

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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 who 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.

New Patient Questionnaire - Hastings

Name_____ DoB _____

We are required to obtain your permission to store your contact details. We will only contact you about appointments or matters relating directly to your healthcare, and we will only share your information in accordance with our Privacy Notice, details of which are available on our website and in our waiting room.

Home Telephone_____ Mobile Telephone_____

Email Address_____

Please nominate a pharmacy for electronic prescriptions _____

Record of Ethnicity and Main Spoken Language

Due to new Government Guidelines we are now required to record a patient's ethnicity and main spoken language. Please tick the relevant boxes below.

Ethnicity

☐ White British ☐ British/Mixed British ☐ Irish
☐ Indian/British Indian ☐ Pakistani/British Pakistani ☐ Chinese
☐ Other (please specify _____

Language

☐ English ☐ Other (please specify) _____

*By completing the following information on this questionnaire you will be helping to ensure our records are kept up to date, thus enabling us to offer you a higher level of care. Thank you.

Do you have any allergies? ☐ Yes ☐ No
If yes please specify _____

Other Information

Height (if known)_____ Weight (if known)_____

Smoking Status

☐ Never smoked tobacco ☐ Ex-smoker – When did you quit? _____
☐ Current Smoker – How many per day? _____

ADVICE: SMOKING KILLS: If you would like help to quit please call the Smokefree Hull Service on 01482 977617 or email hullstopsmoking.info@cgl.org.uk

Alcohol Consumption

Please tick here if you do not wish to complete this section of the questionnaire (continued overleaf) ☐

This is one unit of alcohol…


½ pint of regular beer lager/cider


1 small glass of wine


1 single measure of spirits


1 small glass of sherry


1 single measure of aperitifs

…and each of these is more than one unit

Pint of regular beer/lager/cider

Pint of premium beer/lager/cider

Alcopop or can/bottle of regular lager

Can of premium lager or strong beer

Can of super strength lager

Glass of wine (175ml)

Bottle of wine

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2-4 times per month ☐	2-3 times per week ☐	4+ times per week ☐	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2 ☐	3-4 ☐	5-6 ☐	7-9 ☐	10+ ☐	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/ Almost daily ☐	

Scoring:
A total of 5 indicates increasing or higher risk drinking
An overall total score of 5 or above is AUDIT-C positive

Total Score:

P.T.O

Do you have any significant personal medical history? ☐ Yes ☐ No
If yes, please specify _____

Do you have any significant family medical history? ☐ Yes ☐ No
If yes, please specify _____

Are you taking any regular medication? ☐ Yes ☐ No
If yes, please list here _____

Are you a carer? ☐ Yes ☐ No
If yes, who do you care for? _____

Patient Signature: _____ **Date:** _____

I confirm that the information provided above is accurate at the date of completion. I consent to my contact details being stored in accordance with GDPR and Data Protection Act 2018 and to being contacted by SMS text messaging.

If you would like to join our patient reference group, please ask at reception

Score from AUDIT-C: | Total Score: |

Remaining AUDIT questions

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
Have you or somebody else been injured as a result of your drinking?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐	

Scoring: 0-7 Lower risk, 8-15 Increasing risk, 16-19 Higher risk, 20+ Possible dependence

TOTAL Score equals AUDIT-C score + score of remaining questions

Total score: