



**Merchiston Surgery**

Highworth Road

Stratton St Margaret

Swindon

SN3 4BF

Telephone: 01793 823307

[www.merchistonsurgery.co.uk](http://www.merchistonsurgery.co.uk)

Dr S Adams    Dr C Jacobs  
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Dr L Bond     Mrs H Smalley  
Dr S Shah

Welcome to Merchiston

To enable us to register you we require sight, and copies of two forms of ID chosen from the list below. Ideally one photo ID and one proof of your **current** address should be provided but talk to us if you do not have any photo ID.

- Passport – (this is essential for foreign nationals)
- Driving licence
- ID card
- Birth certificate
- Utility bill
- Letter from benefits agency/benefit book/signing on card
- Papers from the Home Office
- Bank statement

All patients must complete the forms on pages 7-12 enclosed in this pack and the purple form (GMS1). Please complete Carer and Online Access forms only if they apply to you. If you have regular repeat medication please also give us a copy of your medication list which you can obtain from your previous surgery.

Once we have received all of the above information from you, we will register you on our system and allocate you a named GP. This will take up to 5 working days but once you are on the system you will be able to book appointments. All information provided is strictly confidential and will be processed using the Practice's Patient Confidentiality and Data Protection protocols.

Please read all the enclosed information as our procedures may be different to your previous practice.



## TWO WAYS TO ORDER YOUR MEDICATION

### Electronic Prescriptions

All prescriptions will be electronically signed by your GP and you will be given a bar code (unique to your prescription) to take to ANY pharmacy and they will dispense your prescription. If you use a particular pharmacy regularly, you may choose to nominate them or a dispensing appliance contractor (if you use one) and we will send your prescription electronically to them. We can add a nomination for you so you don't need a computer to do this.

### Can I change my nomination?

Yes you can contact us or your pharmacy to change your nomination at any time. Remember to change your nominated pharmacy when you move otherwise your prescriptions will be sent to your old pharmacy.

### Can I get a paper prescription?

No. We no longer issue paper prescriptions.

### Prescription Ordering Direct (POD)

The NHS Prescription Ordering Direct (POD) service is the easy way for you to order your repeat prescription. The POD is staffed by dedicated, experienced and fully trained prescribing clerks and clinical member of the Medicines Optimisation team at the NHS Swindon Clinical Commissioning Group.

Call POD on 01793 683755  
Monday-Friday  
9am to 5pm

We strongly recommend you order your medicines 7 days before you run out, and visit the pharmacy a week after calling POD to collect them. Alternatively you may register for online access and order your repeat medications online anytime.

**Please order online or via POD as we do not accept requests for medication by any other method.**

## **ONLINE APPOINTMENTS AND REPEAT PRESCRIPTIONS PATIENT INFORMATION**

### **Online account**

Patients will need to produce a photographic identity document (passport/driving licence etc.) and give their email address to staff at Reception who will register patient and issue patients with an individual username and password.

### **Once registered the following Services are available online to patients:**

- Making Appointments (GP and selected clinics only)
- Ordering Repeat Medication
- Access to your medical record
- Past & Future Appointments
- Change of Password
- Updating Contact Details

### **Using SystemOnline responsibly and patient confidentiality**

Patients are requested to use the Online System responsibly. If a patient does not then the Practice reserves the right to remove their online access. Examples of improper use of the online system may include repeatedly booking/amending appointments with no intention of attending or repeatedly requesting medication that is not required.

Confidentiality with regard to patient medical information applies equally to the Online System and is strictly adhered to by the Practice and all members of staff.

### **Help with your online account**

Please click on the "help" button to access the online system guide for full details of how to make best use of your account.

## **WHAT WE DO WITH YOUR MEDICAL INFORMATION**

### **What information do we record about our patients?**

The practice stores information on a database about each of its patients. The database is used to record your medical history and any consultations that you may have with a doctor, nurse or health care assistant.

This includes information on all medication (current and discontinued).

We may need to refer you to hospital or other services and we need to gain your consent to do this (see section on YOUR OPTIONS ON SHARING DATA).

All letters, faxes, emails relating to tests, discharge from hospital, out of hours reports, accident and emergency reports are also scanned into each relevant patients records so we have a full and complete medical history.

There is usually a paper file kept for each patient too and these are kept in a secure area in the Practice.

### **How else might your data be processed?**

If you get referred to another service, your information will be shared with this service. Your consent will have been obtained during the GP consultation.

Sometimes the practice is involved in national or local health audits and we may be required to send data to an NHS organisation. However, on these occasions data is sent without personal details so individuals can not be identified.

The practice may be approached by social services or the police for information on patients. Information is not disclosed unless there is a risk to the patient or wider society. The police are usually required to supply a warrant to access data about a patient.

### **How we store your data**

All computerised data is stored on a system that is password protected, with regular password changes. All manual files are kept in a secure area.

When we print off personal information and it is no longer needed, it is kept in shredding consoles and destroyed onsite regularly, by a company called SHRED IT.

## **How do we ensure that your data is safe?**

At Merchiston we have systems in place to ensure that all data stored about each of our patients is processed lawfully.

This means that we have policies in place and staff members are trained to deal with your data sensitively.

## **Everyday confidentiality**

All staff have access to your medical and personal details which is required in relation to their roles. Staff members do not access data unless it is part of their job.

All staff undergo training on confidentiality and have signed a 'Confidentiality Agreement'. They are trained not to disclose information to a third party.

If a relative wants to know information about one of our patients we will not disclose this unless we have written consent from the patient.

If you have concerns or a complaint about how your data is used please speak to one of our receptionists or ask to speak to our Data Protection Officer who will do their best to assist you.

## **YOUR RIGHTS TO ACCESS YOUR DATA**

Under the General Data Protection Regulations 2018, individuals have the right to request access to their own medical record. This can be done by registering for online access or by completing a paper application form "'Application to Access Medical Records' to receive a paper copy of your record. Ensure that the form is fully completed, using a separate sheet of paper if necessary.

We aim to provide on line access and a copy of your paper records (when requested) within 20 working days but the actual time taken may be affected by patient demand.

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## DATA SHARING OPTIONS

Please complete this form and return to reception with your registration form

### The GENERAL DATA PROTECTION REGULATIONS 2018

The General Data Protection Regulations 2018 (GDPR) came into force on 25th May 2018. The regulations require that we gain patient consent regarding how we use your data.

There are 2 parts:

- **Who we share your data with**
- **Whether you consent to having a Summary Care Record.**

Please tick the boxes on the following two pages.

### 1. Who we share your data with

#### We need you to consent to how we share your data.

There are 3 OPTIONS:

(Please select only ONE option)

We share your information with partner organisations such as the hospital (if you need a referral), community teams, Out of Hours services and the Swindon Clinical Commissioning Group who process referrals or via the anonymised audits conducted by NHS England.

You can request that we share with other organisations (as above) but only with added security. This will mean that you get sent a text or email with a pin number when you go to another organisation and they need to access your medical record. They will not be able to open your record without this pin number.

You can request that none of your data is shared with any organisation. If you do need a referral to hospital we will gain your explicit consent at the time of the referral.

## 2. Consent to the Summary Care Record

The Summary Care Record is a basic shared record across health care organisations.

It contains patients' medication, allergies and sensitivities and it may include enhanced information, for example for patients who are at the end of their life and the hospital or a pharmacy may need urgent information about medications.

You have the right to opt out of the Summary Care Record.

Please tick ONE option below:

YES I would like a Summary Care Record.   
(medication and allergies AND additional information)

YES I would like a Summary Care Record.   
(medication and allergies only)

NO I would not like a Summary Care Record.

At Merchiston Surgery we have systems in place to ensure that all data stored about each of our patients is processed lawfully.

This means that we have policies in place and staff members are trained to deal with your data sensitively.

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_



## NEW PATIENT QUESTIONNAIRE

Please complete this form and return to reception with your registration form. Please complete in **block capitals**.

Date: Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_

Post code: \_\_\_\_\_

Telephone Numbers: Mobile: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Text messaging

I consent to Merchiston Surgery contacting me by text message. I am aware that if I share my mobile with another person that they may see text messages from the Surgery that are meant for me.

- I acknowledge the responsibility of attending or cancelling appointments still rests with me.
- I will inform the surgery if I change my mobile telephone number.
- YES- I agree

### Email

- I consent to Merchiston Surgery contacting me by email.
- I will inform the surgery if I change my email address.
- YES- I agree

Do you consider you have a disability? (please circle) NO / YES

If YES, please state type of disability: \_\_\_\_\_

If appropriate please state how you wish to be communicated with? (e.g. large font letters)

\_\_\_\_\_

Do you have a carer? (please circle) NO / YES

Name and address of carer: \_\_\_\_\_

Are you a carer? (please circle) NO / YES

Name of person you care for: \_\_\_\_\_ Merchiston patient: YES/NO

### Ethnic group: (please circle)

This information is important for us when assessing any medical risks associated with your ethnic group.

White - British Irish Other White Background (please specify) \_\_\_\_\_

Mixed - White & Black Caribbean White & Black African White & Asian

Other mixed background (please specify) \_\_\_\_\_

Asian or British Asian – Indian Pakistani Bangladeshi Other Asian (please specify) \_\_\_\_\_

Black or Black British - Caribbean African Other Black background (please specify) \_\_\_\_\_

Chinese Any other ethnic group (please specify) \_\_\_\_\_ 1st Language \_\_\_\_\_

If English is not your 1<sup>st</sup> language do you need a telephone interpreter for consultations? YES/NO

Language required: \_\_\_\_\_

## GENERAL MEDICAL HISTORY

Serious or chronic illnesses (please circle)

Blood Pressure: YES / NO      Diabetes: YES / NO      Heart Disease: YES / NO  
Epilepsy: YES / NO      Asthma: YES / NO      Stroke: YES / NO  
COPD: YES / NO      Depression: YES / NO      Cancer: YES / NO  
Kidney Disease: YES / NO      Glaucoma: YES / NO      Severe Mental Illness/Issues: YES / NO

Other serious / chronic illnesses or serious operations: \_\_\_\_\_

Do you have a family history of?

High blood pressure: YES / NO      Heart Disease: YES / NO      Diabetes: YES / NO  
Glaucoma: YES / NO      Stroke: YES / NO      Asthma: YES / NO  
Cancer: YES / NO      Depression: YES / NO

### Smoking

Do you smoke? YES / NO (please circle)      Never smoked      Ex-smoker  
What do you smoke and how many per day?  
Are you interested in Smoking Cessation Advice? YES/NO

### Alcohol

How much on average do you drink in a week? \_\_\_\_\_  
(1 unit = ½ pint of beer, 1 glass of wine, or a pub measure of spirits)

### Diet

Do you add salt to your food after cooking? Yes/No  
Do you have a varied diet including milk, meat, vegetables and fruit? Yes/No  
Has your Cholesterol been checked in the last 2 years?

## DRUGS AND MEDICINES

What medicines / tablets are you taking? (including contraceptives for females)

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Do you have any allergies?  
Please specify:

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## HEALTH SCREEN

Current Height: \_\_\_\_\_ Current Weight \_\_\_\_\_  
Current Waist measurement: \_\_\_\_\_

## VACCINATIONS

Which vaccinations have you had and when? .....

Diphtheria..... Polio..... Tetanus..... Measles .....

HIB ..... Hepatitis A ..... Hepatitis B .....MMR .....

German Measles / Rubella .....Whooping Cough / Pertussis..... Meningitis.....

Typhoid ..... BCG ..... Yellow Fever ..... Influenza .....

HIB ..... Pneumococcal ..... Others .....

Do you have private medical insurance? YES / NO

**Military Veteran? Service RN/Army/RAF Service No .....**  
**Enlistment Date..... Discharge Date .....**

## FEMALE PATIENTS ONLY

Have you ever had a Cervical Smear? (please circle) YES / NO  
When was your last cervical smear test? \_\_\_\_\_  
Who did it? (please circle) GP Clinic Hospital  
What method of contraception do you use at present? (please circle) Pill Coil  
Injection Implant  
Have you any children? (give ages) \_\_\_\_\_  
Have you had any miscarriages? YES / NO Date:  
\_\_\_\_\_  
Have you had a termination of pregnancy? YES / NO  
Date: \_\_\_\_\_  
Have you had a hysterectomy? YES / NO  
Date: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_

## MERCHISTON PHYSICAL ACTIVITY QUESTIONNAIRE

Please complete this form and return to reception with your registration form.

1. Please tell us the type and amount of physical activity involved in your work.

		<b>Please mark one box only</b>
<b>a</b>	I am not in employment (e.g.: retired, retired for health reasons, unemployed, full time carer etc.)	
<b>b</b>	I spend most of my time at work sitting (such as in an office)	
<b>c</b>	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g.: shop assistant, hairdresser, security guard, childminder etc.)	
<b>d</b>	My work involves definite physical effort including handling heavy objects and use of tools (e.g.: plumber, electrician, carpenter, hospital nurse, gardener, postal delivery workers etc.)	
<b>e</b>	My work involves vigorous physical activity including handling of very heavy objects (e.g.: scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week*, how many hours did you spend on each of the following activities?

		None	Some bit less than 1 hour	1 hour but less than 3 hours	3 or more hours
<b>a</b>	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
<b>b</b>	Cycling, including cycling to work and during leisure time.				
<b>c</b>	Walking, including walking to work, shopping, for pleasure etc.				
<b>d</b>	Housework/Childcare				
<b>e</b>	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow		Steady average		Brisk		Fast	
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less than 3mph)						(over 4mph)	
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Dear Patient

**Do you look after a friend or family member?**

Do you look after someone who is ill, frail, disabled or mentally ill? If so, you are a carer. We are interested in identifying carers, especially those people who may be caring without help or support. We know that carers are often "hidden" looking after a family member or helping a friend or neighbour with day to day tasks and may not see themselves as a carer.

We feel that caring for someone is an important and valuable role in the community, which is often a 24-hour job that can be very demanding and isolating for the carer. We further believe carers should receive appropriate support by way of access to accurate information on a range of topics such as entitlement to benefits and respite care and not least, a listening ear when things get too much.

We hold a Carer's Cuppa meeting on the last Thursday of every month between 10 and 11.45 at Grange Leisure Centre. This is for carers only and is a great opportunity to chat informally with others in a similar position. There is no need to book please just turn up.

If you are a carer, this is an opportunity to let the Practice know so that we can update our records and pass on your details to the Carers Service who can provide relevant information and advice, local support services, newsletter and telephone linkline. We can also refer you to Adult Care Services for a carer's assessment. This is a chance to talk about your needs as a carer and the possible ways help could be given. It also looks at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

Please complete the attached sheet only if you are a carer and return it to the surgery.

We look forward to hearing from you.

Yours sincerely

Paula Cooke,

Operations Manager

**MERCHISTON SURGERY CARER CONSENT FORM**

Thank you for completing the Carer Registration Form. We have now marked your notes to say that you are Carer.

If the person for whom you care is also registered at this practice, it would assist us greatly if we could enter your name and telephone number onto his/her computer notes. This would be particularly helpful in the event of an emergency.

You are under no obligation to agree to this, but if you are willing, please could you complete and sign the relevant section below and return this form to the surgery. The person for whom you care also needs to sign this form. Many thanks.

---

**CARER DETAILS:**

I hereby give permission for my name and telephone to be entered onto the notes of the person named below.

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Tel. number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to cared for: \_\_\_\_\_

**CARED-FOR DETAILS:**

I hereby give permission for the name and telephone of the person named-above to be entered onto my notes as my main Carer.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Carer: \_\_\_\_\_

I GIVE/ DO NOT GIVE (DELETE AS APPROPRIATE) permission for my carer named above to have access to my medical records and personal details held by the Practice. I understand my GP may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

Signature: ..... Date:.....

## MERCHISTON SURGERY

### Application for online access to my medical record

Surname:	Date of Birth:
First names:	
Address:	
Postcode:	
Email address:	
Telephone number:	Mobile number:

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	
2. I will be responsible for the security of the information that I see or	
3. If I choose to share my information with anyone else, this is at my own risk	
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	

Signature	Date
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### For practice use only

Patient NHS number	Method Photo ID and proof of residence Vouching with information in record Vouching
Identity verified by (initials)	Date
Any Additional Comments	
Authorised by	Date
Date account created	
Date passphrase sent	
Record access enabled	Date & Initials