



FRESHWELL HEALTH CENTRE

Information for new patients

Want to fill in an online form instead? Use this QR code to get started, or visit: www.freshwell.co.uk/new-patients



If filling out this paper form, please complete the PRF1 standardised NHS registration questionnaires, as well as the additional questions on the back of this info page

We are a Dispensing Practice

We have a dispensary at the surgery, and you can collect your medications from us, unless you live within **one mile** of a pharmacy. If you would like to collect your medications from us, please leave the pharmacy questions blank (questions 14-16 on page 4).

Online Access

Patients are now able to see their full medical records online via the NHS app or Airmid app. You can access your account with your NHS login. If you do not have an NHS login you can create one in the app or via this website www.nhsapp.service.nhs.uk/login

If you cannot meet the ID requirements for an NHS login, but would still like online access, talk to our team about manually activating your online services.

Some restrictions still exist about what patients can see from before 2nd February 2023 and records from your previous practices will show only detailed coded records, not full records.

Practice Privacy Policy

By completing this form you consent to certain communication pathways and supplying the practice with other information that could improve your care. All information is stored in line with our GDPR policy. Please see our practice privacy notice for patients on our website:

www.freshwell.co.uk/practice-fair-processing--privacy-notice

Sexuality and Gender Monitoring

This section is optional but can help us provide the most relevant care to you

How would you describe your gender?

Is your gender the same as you were assigned at birth?

Yes

No

If no, we may contact you to discuss which screening services are appropriate to offer you

Please tick here if you are NOT comfortable with us contacting you about screening

What are your pronouns? You can write in alternative options if needed.

He/Him/His She/Her/Hers
_____/_____/_____

Firearms Licence

Do you have a firearm licence?

Yes

No

Does a member of your household have a firearm licence?

Yes

No

What date was the licence issued?

Consent to Share Information

We will not discuss your health with any friends or family without your permission. If you would like us to talk to someone about your health, please complete the section below

I give my consent for the surgery to share the following information:

My full record and all aspects of my care

Other information only (please specify)

With the named person(s) below:

| | | | |
|---------|--|-------------------------|--|
| Name | | Relationship | |
| Address | | Phone | |
| Name | | Relationship to patient | |
| Address | | Phone | |

These instructions are valid from:

Start date

End date

If no end date is specified, the Surgery will accept this as a permanent instruction

Signature of patient for consent to share records

Print name

Signature