**NORTH RIDGE MEDICAL PRACTICE**

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1. **PLEASE COMPLETE ALL THE FOLLOWING PERSONAL INFORMATION FOR SECTION 1 & 2**

**(1 FORM PER PATIENT):**

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| --- | --- |
| **Name and Surname** |  |
| **Date of Birth** |  | **Current Age** | \* |
| **Home telephone number** |  |
| **Personal Mobile number if age 13 and over** |  |
| **Personal email address if age 13 and over** **(one per patient / no shared e-mails unless under 13 or consent from all parties)** |  |

**\*if patient is under 16, parental consent is required. Please sign relevant section below**

1. **NEXT OF KIN AND EMERGENCY CONTACT INFORMATION TO BE HELD ON OUR DATABASE:**

In order for us to improve patient safety and care, we would appreciate if you could ensure that we have your next of kin contact data in case of an emergency. Please ensure that your nominated Next of Kin/Emergency Contact is aware that we hold their details on our database.

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| **Nominated Next of Kin:** |  |
| **Contact number:** |  |
| **Address:** |  |
| **Relationship:** |  |

**In case of emergency, if different from above:**

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| --- | --- |
| **Emergency Contact Name:** |  |
| **Contact number:** |  |
| **Address:** |  |
| **Relationship:** |  |
| **I confirm that I have notified my Next of Kin and Emergency contact and that they have provided verbal consent to hold their data at the surgery** | **🞏** |

1. **WAYS WE MAY USE YOUR CONTACT DETAILS:**
	1. **DIRECT CARE MESSAGING: (NO CONSENT REQUIRED)**

Collecting and using email addresses and mobile numbers for direct medical care such as appointment reminders, test results, annual reviews, vaccination invitations, responses to E-consultations etc. These are all examples of direct care messaging. This is the primary reason to hold your information as part of our duty of care. **We may lawfully contact you under**  **GDPR Articles 6(1)(e) and 9(2)(h) to provide health care as this forms part of our legal compliance with our contract.**

Please also refer to our Privacy Notice on our website –

https://www.north-ridge-surgery.co.uk/privacy-notice

**OR** this is also available in the waiting room and reception.

* 1. **SURGERY NEWS AND EVENTS (NON DIRECT CARE): (CONSENT REQUIRED)**

North Ridge Medical Practice may from time to time communicate with our patients via email or text messaging to convey practice information or events, such as Patient Participation Group (PPG) Health Events, surgery closures for Protected Learning Time, Quarterly Surgery Newsletter etc. You may opt in or out to receive this information. For this we would however require your **consent**, please select the appropriate option under section 3.2.1.

**PLEASE NOTE: Due to clinical system limitations, if you OPT OUT of receiving text messages, you will not receive any Direct Care Messages either, such as Appointment reminders when registered for online services.**

* + 1. **PLEASE COMPLETE ALL THE CONSENT INFORMATION BELOW REQUIRED AS PART OF GDPR:**

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| **REASON FOR CONSENT** | **CONSENT GIVEN / OPT IN****(✓)** | **CONSENT DECLINED / OPT OUT****(✓)** |
| * to leave messages on telephone answer machine / voicemail
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| * to communicate blood results, diagnosis etc. with my next of kin if I am not available
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| * to leave phone messages with my next of kin if I am not available
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| * ***Email:*** to receive non direct care communications from the surgery via e-mail which may include surgery closures, PPG health events, quarterly newsletter, appointment reminders etc.

(See definition under section 3.2) | 🞏 | 🞏 |
| * ***Mobile:*** to receive non direct care communications from the surgery via text messaging which may include appointment reminders, surgery closures, PPG health events, etc. (See definition under section 3.2, please note that if you opt out, we are unable to send reminders for your appointments due to system limitations)
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| * to share **CORE DATA** to the Summary Care Record / hospitals **(*core data includes allergies, current medications, adverse reactions to medication*)**
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| * to **SHARE ENHANCED DATA** to Summary Care Record / hospitals **(enhanced data  *may include long term medical conditions, significant medical history, specific communication needs, which you agree to in the event of an emergency or patient safety)***
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**\**PATIENTS UNDER THE AGE OF 16***

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| **NOTE: If patient is under the age 16 parental consent is required, please sign below:**­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NAME & SURNAME OF PARENT /** **GUARDIAN SIGNATURE DATE** |

I hereby understand that my contact details may be used to communicate Direct Care Information to me where appropriate. I agree that my personal information is correct as indicated on this form and that I will inform the surgery of any changes.

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| This consent is to remain in place until further written notice of cancellation by myself. |
|  |  |
| **PATIENT’S SIGNATURE** | **DATE** |