**NORTH RIDGE MEDICAL PRACTICE**

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| **PARTNERS:**  **Dr Ann Wood**  **Dr R Blundell**  **Dr D Strange** |  | **North Ridge, Rye Road**  **Hawkhurst**  **Kent TN18 4EX**  **Tel 01580 753 935**  **Fax 01580 754 452**  **VAT No: 876012819** |

1. **PLEASE COMPLETE THE FOLLOWING PERSONAL INFORMATION (1 FORM PER PATIENT):**

|  |  |  |  |
| --- | --- | --- | --- |
| **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. **WAYS WE WILL USE YOUR CONTACT DETAILS:**
   1. **DIRECT CARE MESSAGING:**

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):**

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.

**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.**

1. **PLEASE COMPLETE ALL THE CONSENT INFORMATION BELOW:**

|  |  |  |
| --- | --- | --- |
| **REASON FOR CONSENT** | **CONSENT GIVEN / OPT IN**  **(✓)** | **CONSENT DECLINED / OPT OUT**  **(✓)** |
| * **I hereby give consent to leave messages on telephone answer machine / voicemail** | 🞏 | 🞏 |
| * **I hereby give consent to receive non direct care communications from the surgery via e-mail which may include surgery closures, PPG health events , quarterly newsletter etc.**   **(See definition under section 2)** | 🞏 | 🞏 |
| * **I hereby give consent to receive non direct care communications from the surgery via text messaging which may include surgery closures, PPG health events, etc. (See definition under section 2, please note that if you opt out, we are unable to send reminders for your appointments due to system limitations)** | 🞏 | 🞏 |
| * **I hereby give consent to share data i.e blood results, diagnosis etc. with specified 3rd party (spouse, partner, Next of Kin, etc.)** * **Please specify 3rd party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Contact details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 🞏 | 🞏 |
| * **I hereby give consent to leave phone message with specified 3rd party (i.e. spouse, partner, Next of Kin, etc.)** * **Please specify 3rd party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** * **Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 🞏 | 🞏 |
| * **I hereby give consent to share core data to the Summary Care Record / hospitals (this data includes allergies, current medications, adverse reactions to medication)** | 🞏 | 🞏 |
| * **I hereby give consent to share core and additional data to Summary Care record / hospitals (this may include more information which you agree to in the event of an emergency or patient safety)** | 🞏 | 🞏 |

**\**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 SIGNATURE DATE** |

**I hereby understand that my contact details may be used to communicate Direct Care Information to me or to my specified 3rd party member (i.e. spouse, partner, Next of Kin) 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.**

**This consent is to remain in place until further notice of opting in or opting out by myself.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE DATE**

In order for us to improve patient safety and care, we would appreciate if you could ensure that we have your next of kin data in case of an emergency. We would however require their consent to hold their data on our record.

Therefore, please ensure that your nominated next of kin provide consent below or where they are far away that they provide verbal consent.

1. **PATIENT CONSENT TO SHARE INFORMATION WITH NEXT OF KIN:**

|  |  |  |
| --- | --- | --- |
| **Nominated Next of Kin:** |  | |
| **Telephone number:** |  | |
| **Address:** |  | |
| **Relationship:** |  | |
| This consent is to remain in place until further written notice of cancellation by myself. | | |
|  | |  |
| **PATIENT’S SIGNATURE** | | **DATE** |

1. **IN CASE OF EMERGENCY IF DEFFERENT FROM ABOVE CONTACT:**

|  |  |
| --- | --- |
| **Name:** |  |
| **Telephone number:** |  |
| **Address:** |  |
| **Relationship:** |  |
| This consent is to remain in place until further written notice of cancellation by myself. | |
|  |  |
| **PATIENT’S SIGNATURE** | **DATE** |

1. **NEXT OF KIN CONSENT: INFORMATION TO BE HELD BY NORTH RIDGE MEDICAL PRACTICE**

**I the nominated Next of Kin** hereby give consent for the practice to hold my information and to contact me when required. I confirm that the details above are correct.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **NEXT OF KIN NAME & SURNAME** | **SIGNATURE** | **DATE** |
| **VERBAL CONSENT GIVEN AS UNABLE TO SIGN IN PERSON** | | **🞏** |