Waterside Medical Centre

# Patient Maternity Services Registration Form

Please complete this form in BLOCK CAPITALS and tick ✓ or delete as appropriate.

Title:

Mrs ○ Miss ○ Ms ○ Other _____

Date of Birth: _____

Forenames: _____

Surname: _____

Previous Surname: _____

NHS Number: _____

Email Address*: _____

Home Telephone*: _____

Current Home Address:

_____

_____

_____

_____ Post Code: _____

Mobile Telephone*: _____

Work Telephone*: _____

I wish to register at Waterside Medical Centre for the following service(s):

○ Maternity Medical Services only *(complete pink section below and white section on ethnic origin on page 3)*

○ I wish to register *a carer* or *cared for* status *(complete orange section on page 3)*

## I am registering for Maternity Medical Services

○ I wish you to provide maternity medical services

○ I have cancelled arrangements made with my previous doctor, if relevant

Previous Doctor's name: _____

Previous Doctor's address:

_____

_____

_____

○ I am a temporary resident and I wish you to provide maternity medical services whilst I am at this address

Temporary address in Gosport:

_____

_____

_____

○ I have made arrangements for maternity medical services in my home area with this doctor

Doctor's name: _____

Doctor's address:

_____

_____

_____

○ I have received maternity medical services from you as an emergency

### *Basic Communication

By giving us your telephone number(s) and/or email address, you consent to us contacting you on an ad-hoc basis to arrange or re-arrange appointments or for medical reasons, eg giving out a test result, etc. In the case of mobile numbers, we may use SMS text messaging to alert you to the fact that we are trying to contact you by telephone for one of the above reasons. We may also pass your details on to another NHS or NHS-partnered organisation to assist them in providing healthcare services for you as agreed between you and your doctor/nurse. We will never hand your information over to any non-allied organisation. **This is our minimum level of communication we require from you.**

### *Enhanced Services

We are enhancing our administration systems so that we can send you appointment reminders, appointment cancellations and recall invitations, eg 'flu vaccinations or chronic disease management reviews. In the future we also hope to be able to offer more text and email services, eg test results. Your email address will be used for things such as security verification to enable future online services.

If you **do not** wish to be included in this enhanced service, please tick here ○

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○ Signature of patient ○ Signature on behalf of patient Date

_____ _____

To be completed by the doctor

The Patient

Expected confinement date _____ Booking date _____

○ Was confined on _____ ○ In the GP Unit at _____

○ Had a miscarriage on _____ ○ In the hospital _____

○ At home or elsewhere *please specify* _____

Doctor's Name HA code

_____ _____

○ Complete maternity medical services ○ Miscarriage

○ Care in confinement ○ Antenatal care

○ Complete postnatal care Date of discharge from hospital _____

○ Partial postnatal care. Please give dates of attendance

1st _____ 2nd _____ 3rd _____

4th _____ 5th _____ Full postnatal examination _____

○ Claim for anaesthetist's services. Doctor's name _____

○ Emergency treatment for miscarriage or treatment in circumstances where I considered it necessary, in the patient's interest, not to ask for her signature

Date of last service to patient (must be specified for all claims) _____

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date

_____ _____

My ethnic origin is:

Having information about patients' ethnic groups would be helpful for the NHS so that we can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information, you do not have to do so. You may indicate this by ticking the last box.

Your answer to this question will not affect your care.

| | | | |
|---|---|---|---|
| ○ White | ○ White British | ○ White Irish | ○ White Scottish |
| ○ White other | ○ White British Other | ○ Black Caribbean | ○ Black African |
| ○ Black other, non-mixed | ○ Black British | ○ Black West Indian | ○ Black Guyana |
| ○ Black North African | ○ Black Arab | ○ Black Iranian | ○ Black other African country |
| ○ Black East African Asian | ○ Black Indo-Caribbean | ○ Black Indian sub-continent | ○ Black – other Asian |
| ○ Black – other mixed | ○ Indian | ○ Pakistani | ○ Bangladeshi |
| ○ Chinese | ○ Greek (NMO) | ○ Greek Cypriot (NMO) | ○ Turkish (NMO) |
| ○ Turkish Cypriot (NMO) | ○ Other European | ○ Vietnamese | ○ Irish Traveller |
| ○ Other ethnic group | ○ Traveller – gypsy | ○ Do not wish to state | |

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## I am registering a carer or cared for status

○ I am already a patient at Waterside and wish to register as a carer for another patient here

○ I want to register as a patient at Waterside and also as a carer for another patient here

○ I am not a patient at Waterside and just want to register as a carer for a patient here

○ I am already a patient at Waterside and want to register another patient as my carer

○ I am already a patient at Waterside and want to register as a carer of a patient at another practice

Patient's name:
_____

Patient's address:
_____
_____
_____

Patient's Date of Birth
_____

Doctor's name:
_____

Doctor's address:
_____
_____
_____