FOR US TO RECORD YOUR SCR PREFERENCE PLEASE READ AND COMPLETE THIS FORM

(Please ensure you tick a box below and sign the form at the bottom)

Patient Name ....

Date of Birth ....

NHS Number *(if known*) ....

Forrest Medical Centre offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record is being introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record will contain basic information about any **allergies you may have, unexpected reactions to medications and any prescriptions you have recently received**. The intention is to help clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Children under the age of 16

Patients under 16 years will not receive this letter, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.**

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you decide to proceed, but at any time in the future you, or a child you are responsible for, change your mind and choose not to have a Summary Care Record, all you need do is write to your Surgery informing them of your decision to "Opt-out". If you have already told your Surgery that you wish to "Opt-out" and you wish this to remain in place you need take no further action.

Additional information included in the SCR

The 'additional information' set has been defined and signed off by clinical groups and suppliers. SCRs with additional information incorporate individual coded items and associated free text and will include:

- Reason for medication
- Significant medical history (past and present)
- Anticipatory care information (such as information about the management of long term conditions)
- Communication preferences
- End of life care information
- Immunisations

Please tick box so we can record your Summary Care Record preference:

No, I would not like to have a Summary Care Record ☐
Yes, I would like to have a Summary Care Record ☐
Yes, I would like a Summary Care Record with Additional Information ☐

If you **want** a basic Summary Care Record **you do not have to do anything**, it will automatically be created for you.

Signed by Patient………………………………………………………………………..