

## Patient Registration and Medical Summary Form

In order to provide for your care, we need to collect and keep information about you and your health in your personal medical record. Please complete the following form. The information will be used to create your personal medical record on the practice computer.

Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts. For further details please see our Practice Privacy Statement

<u>Administration Details</u>	<u>Health History</u>
<p><b>First name:</b></p> <p><b>Surname:</b></p> <p><b>Title: Mr. /Mrs./Ms./ Other</b></p> <p><b>Date of birth:</b></p> <p><b>Gender: Male / Female</b></p> <p><b>Address</b></p> <p><b>Phone:</b></p> <p><b>PPSN:</b></p> <p>I am happy to receive specific medical alerts (test results and cervical check / chronic disease clinic appointments only) from the practice by Mobile phone (SMS) <input type="checkbox"/>.</p> <p><b>GMS number:</b>                      <b>Expiry date:</b></p> <p>I agree to partake in Chronic disease management Yes</p> <p><b>Next of kin:</b></p> <p><b>Relationship:</b></p> <p><b>Phone:</b></p> <p><b>Previous GP Practice name and address:</b></p> <hr/>	<p><b>Allergies:</b></p> <p><b>Medical history</b></p> <p><b>Surgical history:</b></p> <p><b>Current medication:</b></p> <p><b>Why are you leaving your current GP?</b></p> <p style="text-align: center;"><b><u>Patient Statement</u></b></p> <p>I _____ (print name)</p> <p>Have received a copy of our practice privacy leaflet and data processing agreement</p> <p>Signed:</p> <p>Date:</p>



**Re: Change of Doctor**

**Patient Name:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_/\_\_\_/\_\_\_

Dear Dr

The above-named patient has transferred to this practice and I would be grateful if you could release the relevant past medical records at your earliest convenience. Please forward to rathfarnham.medical@healthmail.ie if you have a practice healthmail account.

Yours sincerely,

\_\_\_\_\_  
Dr.Joanne Cull / Dr Ailbhe Smyth

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## **PATIENT AUTHORISATION**

I authorise Dr \_\_\_\_\_ to release my past medical records, letters, laboratory results, etc., to Rathfarnham Medical Centre, 4 Glendoher Road, Rathfarnham, Dublin 16.

Signed: \_\_\_\_\_

Date:

*Please see our Data Protection / Information Practices Notice in your booking pack to see how we use your personal information*



**Rathfarnham  
Medical  
Centre**

Dear Sir/Madam,

We are happy to accept new patients here at our surgery in Glendoher Road, but we must make you aware of some recent changes we have made to our prescribing of certain medications.

The medications that we no longer initiate on prescription here are:

Valium, Xanax and other benzodiazepines  
Zopiclone, zolpidem and other sleeping tablets  
Tylex  
Solpadol  
Tramadol  
Oxycontin, oxycodone  
Palexia (tapentadol)  
Lyrica

The reason for this is that these medications are highly addictive substances and also, they can be used as drugs of abuse and sold on the street. We do not want to contribute to this in any way. They can also cause some physical problems such as liver damage.

The government wants GPs to clamp down on prescribing these drugs also and a national strategy has been launched to make people aware of the dangers of these drugs, particularly benzodiazepines.

While some patients attending here already are taking these medications, these are longstanding prescriptions, and they are being reduced by their GP over a period of time.

We will not be prescribing these drugs to new patients who will be attending the practice.

We are asking you to sign a form to state that you are aware of this practice policy.

Patients Name: \_\_\_\_\_

Patients Signature: \_\_\_\_\_

D.O.B: \_\_\_/\_\_\_/\_\_\_

Thank you very much for your co-operation,

Dr. Ailbhe Smyth and Dr Joanne Cull.