BELLVIEW CLINICS
PATIENT REGISTRATION & MEDICAL SUMMARY FORM

Important Information

In order to provide appropriate and safe medical care, we need to collect and maintain information about you as part of your personal medical record. Please complete this form as fully and accurately as possible. The information provided will assist the practice in assessing your healthcare needs and ensuring that we have the appropriate resources, clinical expertise and capacity to provide your care. All information will be managed in accordance with applicable data protection legislation, Medical Council guidance and the practice Privacy Statement.

Completion of this form does not in itself guarantee registration with the practice. Applications may require review by the practice where there is clinical, prescribing, administrative or capacity considerations.

SECTION 1 – PERSONAL DETAILS

Title: Mr, Mrs, Ms, Other _____
Last name: (as per passport) _____
First name: (as per passport) _____
Known as: _____
Date of Birth: _____
Gender: _____
Postal address: _____
_____

_____
Eircode: _____
Mobile: _____

SECTION 2 – PPSN / MEDICAL CARD/HEALTH INSURANCE

PPSN: _____
Do you have a medical card? Yes / No _____
Medical Card Number: _____
Expiry Date: _____
Do you have Private Health Insurance? _____
Yes / No
Name of Private Health Insurance Company: _____
Policy Number: _____

SECTION 3 – PREVIOUS GP / MEDICAL PRACTICE

Name of previous GP: _____

Name and address of previous GP practice: _____

_____

Are you currently registered with another GP practice? Yes/No _____

What is your reason for changing GP practice? Give details _____

_____

_____

Are there any current medical issues concerning your medical care which you believe we at Bellview Clinics should be aware of? (i.e. prescribing, referrals, transfer of records) Yes/No

_____

_____

_____

SECTION 4 – ALERGIES &MEDICAL HISTORY

Allergies – please list any known allergies, including medication allergies: (if no allergies please write None)

_____

_____

Significant Medical History – Please provide details of any significant current or previous medical conditions:

1._____

2._____

4._____

5._____

Hospital / Specialist Care

Are you currently attending any hospital, consultant, specialist or other healthcare service? Yes/No (If yes please provide details)

_____

_____

Service / Consultant:

_____

Condition / Reason for attendance: _____

_____

_____

SECTION 5 – CURRENT MEDICATION

Please list all medicines you are taking, including medicines prescribed by your GP, hospital consultant, specialist, dentist or any other healthcare professional.

Medication	Dose	How Often?	Prescriber?

Please include over-the-counter medicines, supplements and medicines obtained from sources other than this practice where applicable.

SECTION 6 – CONTROLLED / HIGH-RISK / SPECIALIST MEDICATION

This section is important to allow the practice to determine whether it has the appropriate clinical expertise, prescribing arrangements and capacity to meet your healthcare needs.

Are you currently prescribed or taking/receiving any of the following? Please tick below.

□ Methadone or other opioid substitution treatment
□ Buprenorphine / Suboxone or similar treatment
□ Strong opioid medication
□ Benzodiazepines or other controlled medicines
□ Stimulant medication, including medication requiring controlled-drug prescribing
□ Medication of complex chronic pain
□ Medication requiring regular specialist monitoring
□ Medication prescribed under a shared-care arrangement
□ Any other medicine which you consider particularly important or complex
Yes / No
List medication / treatment: _____
_____
_____
Dose: _____
Prescribing doctor /service: _____
Hospital / specialist / addiction service, if applicable: _____

_____

_____

Pharmacy: _____

Are there any other medicines which you are currently receiving which you expect this practice to prescribe or continue prescribing? Yes / No (If yes please provide details)

_____

_____

Please note:
The practice will assess requests for prescribing and ongoing management in accordance with its clinical responsibilities, prescribing policies, available expertise and capacity. Registration does not automatically mean that the practice will assume responsibility for prescribing medication previously prescribed by another doctor or service.

SECTION 7 – OTHER RELEVANT INFORMATION

Is there any other information concerning your health, medication, treatment or healthcare needs which you believe the practice should know when considering your application for registration?

_____

_____

_____

_____

SECTION 8 – EMERGENCY CONTACT

(providing this information does not give the named person permission to access your medical file or act on your behalf to make or amend appointments)

Name: _____
Relationship to you: _____
Address: _____
Mobile: _____

SECTION 9 – COMMUNICATION

I consent to receiving text messages relating to my healthcare from this practice. Yes / No
I consent to receiving emails relating to my healthcare from this practice. Yes / No
I consent to receiving emails / text messages from this practice relating to marketing. Yes / No

Note: Text messages and email correspondence may contain appointment reminder, test results and other information relating to your care.

SECTION 10 – PRACTICE GUIDELINES

1. I confirm that I have been provided with, or have has access to, the Bellview Clinics Practice Guidelines.
2. I understand that the practice operates as a group practice and that I may be seen by another doctor or member of the clinical team where appropriate.
3. I agree to comply with the Practice Guidelines and understand that the practice expects all patients and staff to treat one another with courtesy and respect.
4. I understand that failure to comply with the Practice Guidelines, particularly where behaviour creates a risk to staff, doctors, patients or the operation of the practice, may result in the practice reviewing my ongoing registration.

DECLARATION

1. I confirm that the information provided on this form is accurate and complete to the best of my knowledge.
2. I understand that it is important to inform the practice of relevant medical conditions, allergies and medication, particularly controlled or high-risk medication and treatment provided by another doctor or healthcare service.
3. I understand that completion of this form does not automatically guarantee acceptance or registration with the practice and that the practice may need to assess whether it has the appropriate clinical expertise, resources and capacity to provide my healthcare safely and appropriately.

Print patient name: _____

Patient signature: _____

Today's Date: _____

OFFICE USE ONLY

Application received by: _____
Date received: _____
Application reviewed by: _____
Date reviewed: _____
Registration: Approved / Further review required / Not accepted *(circle one)*
Comments: _____
_____
_____