

## Patient's details

Please complete in BLOCK CAPITALS and tick ☒ as appropriate

☒ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

KERR

Date of birth 2/9/11/79

First names

COLIN

NHS No.

Previous surname/s

☒ Male ☐ Female

Town and country of birth

GLASGOW

UK

Home address

ACORN HOUSE, 116-118 SHOREDITCH

HALF STREET LONDON

Postcode

E1 6JN

Telephone number

07554585417

## Please help us trace your previous medical records by providing the following information

Your previous address in UK

WILLOWBY HOUSE  
UPPER BRAGHTON  
LE14 3BH

Name of previous doctor while at that address

Keyworth Medical practice  
Bunney lane Keyworth  
NOTtingham NG12 5JU

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK,  
date of leaving

Date you first came  
to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or  
Personnel number

Enlistment  
date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances\*

\*Not all doctors are  
authorised to  
dispense medicines

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient

☐ Signature on behalf of patient

Date

**NHS Organ Donor registration**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- ☐ Any of my organs and tissue or  
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

For more information, please ask at reception for an information leaflet or visit the website  
[www.uktransplant.org.uk](http://www.uktransplant.org.uk), or call 0845 60 60 400.

**NHS Blood Donor registration**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

For more information, please ask for the leaflet on joining the NHS Blood Donor Register  
 My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: \_\_\_\_\_

**To be completed by the doctor**

Doctors Name

HA Code

- ☐ I have accepted this patient for general medical services  
☐ For the provision of contraceptive services  
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- ☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient or  
☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient

Doctors Name, if different from above

HA Code

- ☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval  
☐ I am claiming rural practice payment for this patient.  
 Distance in miles between my patient's home address and my main surgery is \_\_\_\_\_

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Practice Stamp

**HA use only** Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

**Health E1**  
**Homeless Medical Centre**  
**9-11 Brick Lane**  
**London**  
**E1 6PU**

**NEW PATIENT REGISTRATION FORM & CONTRACT**

Full Name: COLIN KERR  
 Date of Birth: 29/11/1979 (Male) Female:  
 Address: Acorn House, 116 – 118 Shoreditch High Street, London, E1 6JN  
 Next of kin or close friend (Name): CALARE  
 Telephone number: 078 141 35871  
 Town & Country of Birth: 29/11/79  
 NHS Number:  
 Email Address:  
 Date of Arrival in UK: N/A  
 Nationality: British

**HOUSING STATUS**

Please tick most relevant box

No fixed abode	
Living in a Hostel	✓
Bed and Breakfast	
Living with Friends	
Squatting	

**MARITAL STATUS**

Please tick most relevant box

Single	✓
Married	
Separated	
Divorced	
Widowed	
Living with Partner	

**ETHNIC GROUP**

Please tick most relevant box

White English	✓
Scottish	
Welsh	
White Irish	
Greek	
Turkish	
Eastern European	
Jewish/Orthodox Jew	
Other White/Mix White	
White and Black Caribbean	
White and Black African	
White and Asian	
Other Mixed	
Indian or British Indian	
Pakistani or British Pakistani	

Other Asian	
Black Caribbean	
Somali	
African	
Black British	
Other Black	
Chinese	
Arab or Middle East	
Kurdish	
Vietnamese	
Traveller	
Any other group	
Patient Refused	
Other	
Bangladeshi or British Bangladeshi	

**LANGUAGE**

Please tick most relevant box

English	✓
Bengali (Sylheti or Standard)	
Arabic	
Cantonese	
Vietnamese	
Somalian	
Hindi	

Albanian	
Amharic	
Czechoslovakian	
Farsi	
French	
Polish	
Portuguese	

Gujerati		Russian	
Punjabi		Spanish	
Urdu		British Sign language	
Turkish		Other Language	

#### **Health E1 Registration Contract**

*Health E1 is a medical centre for homeless people and as such is aware of how difficult it may be for some people to acquire proof of identification (I.D.). In order to combat this we ask that you sign the following contract. The contract will be kept on your file for the length of time that you remain registered at Health E1.*

**In signing this contract you are confirming that:**

- **You are the person that you claim to be and that all information given on your registration form is correct to the best of your knowledge and that you have not deliberately withheld information about yourself.**
- **You are not registered with, or receiving any kind of medication from, any other organisation either within or outside of the United Kingdom.**
- **The name, age and care of details that you have given us today are not an alias or false.**

In return Health E1 will guarantee that information given to us by yourself will be deemed private & confidential unless otherwise stated by you. If it does become necessary for us to share or obtain medical information on your behalf from other outside agencies we will obtain written consent from you first.

If you do not attend the practice for two years the practice will automatically remove you from our practice list.

**Please be aware that if after signing this contract we find that you have given false information in order to obtain medical treatment, Health E1 reserves the right to remove you from our list and to take any further action that might be necessary.**

Signed: *C. Kerr*  
Print Name: *Corn Kerr*

Dated: *5/12/2025*  
Date of Birth: *29/12/1979*

#### **Permission to open my post**

For patients who are street homeless / have no temporary address, Health E1 is willing to receive health, housing and benefits related post on your behalf. As post often contains appointment details please be aware it is your responsibility to check for post frequently.

We will not contact you to inform you if you have post but if you come in or phone us we will let you know.

We will save the post for a time period of 3 months. If you have not collected your post by the end of this time period the letters will be returned to sender or placed in our confidential waste if there is no return address.

If you later become housed in temporary or permanent accommodation we will no longer agree to receive your post and you will need to have it redirected. If you have not collected it after three months we will return it to sender or dispose of it in our confidential waste.

- There may be times when confidentiality has to be broken, especially when there is a risk of significant harm to me or other people. When this happens you may not ask for my consent or tell me ☐
- Usually you will ask for my consent before sharing my personal information. If I am incapable of making a decision, a Court may appoint a Deputy to make the decision ☐
- I may make an advanced statement of my wishes concerning my care and treatment and the Trust will have regard to these expressed preferences when planning my care and support ☐
- You will send me text reminders to my mobile phone if I have given you my contact number ☐
- You can contact me about my health by email at my email address ..... I will send you an email from this account as confirmation ☐
- You can link my record with other family members receiving care from you provided they also give their consent ☐

Name of service user / representative completing form:

Signature: *e. l. c. e. r. v.*

Date: *5/12/2025*

Name of worker: *Nora O'Brien*

Signature: *[Signature]*

Date: *5/12/2025*

**Agencies / individuals I do not want you to share my information with**

Please give us details of any agency that you do not want your information shared with. This may affect the level of care we give you.

Agency	Individual	SU initials

**Carer Status:**

Is a Carer ☐

Not a Carer ☐

Is no longer a carer ☐

**Emis Sharing Consent:**

Does the patient consent to their detailed records being shared across organisation boundaries

Patient consents to sharing the detailed records ☐

Patient does not wish to share the detailed records ☐

**SCR Consent:**

Change patient's Summary Care Record consent preference

Express consent for medication, allergies, and adverse reaction only ☐

Express consent for medication, allergies, and adverse reaction, and additional information ☐

Express dissent (opted out) – Patient does not want a summary care record ☐

**The Electronic Prescription Service (EPS):** EPS allows prescriptions to be sent direct to pharmacies through IT systems used in GP surgeries.

Please read and sign below to indicate that you are in agreement with these conditions.

**It is my responsibility to collect my post on a regular basis**

**I understand and agree that my post will be held at Health for 3 months and that if I do not collect my post within 3 months from date of receipt, Health E1 staff will return my post back to the sender or place it into the confidential waste.**

Patient's Name (PLEASE PRINT)

Patient's Signature

COUN KERR

C. Kerr

Date of Birth 29/11/1979

Today's Date 5/12/2025

**Permission to Use and Share Information**  
**Consent form and declaration**

Service user's name:	NHS no:
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Please tick the relevant boxes below

I am the service user	<input checked="" type="checkbox"/>
I have read the information in the Trust's leaflet 'Your records and you' and my worker has explained how my information will be used and shared	<input checked="" type="checkbox"/>

I have the authority to act for the service user because: (Please explain why, below. You must have a valid reason and be able to provide documentation to support this)	<input checked="" type="checkbox"/>
I have read the information in the Trust's leaflet 'Your records and you' and the worker has explained how the service user's information will be used and shared	<input checked="" type="checkbox"/>
Please note in the sections below that you are agreeing to the way the Trust uses and share the information of the <u>person you are responsible for</u> :	

I understand and agree that:

- My health record will be held on your local electronic health records system and that if I refuse to have my personal information held in this way you may be unable to care for me and ask me to seek care elsewhere
- My personal information will be shared with individuals and agencies involved in my care, including my career and in some circumstances my family
- I may put limits on what can be shared, and who with. If so, I will list at the bottom of the page who you may not share my information with. This could mean you are unable to care for me and ask me to seek care elsewhere
- Other agencies will share their information about me with you
- You may actively encourage my family, carer or other individuals to share information about me

<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>