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| BAWTRY AND BLYTH MEDICAL | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Bawtry Health Centre,**  **Station Road,**  **Bawtry,**  **Doncaster,**  **South Yorkshire, DN10 6RQ** | **DR D.J. THOMAS**  **DR T. WONG**  **Medical Practitioners**    **Telephone 01302 710210**  **Facsimile 01302 710261** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **1 High Street,**  **Blyth,**  **Worksop,**  **Nottinghamshire,** S81 8EQ |

[**www.bawtryandblythmedical.co.uk**](http://www.bawtryandblythmedical.co.uk)

**APPOINTMENT REMINDERS AND PATIENT ONLINE**

In line with other N.H.S. providers, Bawtry and Blyth Medical have installed a system to remind patients that they have an appointment at the surgery with either the doctor or nurse. For this to take place we need to know your mobile telephone number for us to send a text message to you about 2 days prior to your appointment.

You are also able to register for an online account which will allow you to book an appointment, request a repeat prescription, view your Summary Care Record and view your coded history. Your Summary Care Record contains a list of your repeat medicines, a list of non-repeat medicines prescribed within the last six months, and a list of any allergies or adverse reactions we have recorded for you. Your coded record contains a list of all medical issues or problems you have seen a clinician about throughout your life. If you would like an online account, please complete the form overleaf and return it to the surgery either by post or email. We will contact you to confirm the details and your access details will then be sent to you. **You must have an e-mail address to have an online account.**

This service will only work if you keep us up-to-date with any changes to your mobile telephone number or email address. If you change your mobile telephone number or email address please inform the surgery.

Many thanks for your help in this project.

Name:

Address:

Mobile Telephone Number:

Email Address:

**PLEASE SIGN TO INDICATE YOUR ACCEPTANCE THAT YOU ARE RESPONSIBLE FOR INFORMING THE PRACTICE IF THE ABOVE DETAILS CHANGE FOR ANY REASON**

**SIGNED:**

**DATE:**

I would like a Patient Online account, and would like access to (please circle):

Online Appointment Booking YES/NO

Online Repeat Prescription Ordering YES/NO

My Summary Care Record YES/NO

My Coded Medical History YES/NO

**Receptionist to Complete:**

Identity Confirmed: YES/NO

Name: Date: