General Medical Practice

Blackbird Clinic
Unit 4 Southpoint, 60 Main Street,
Bray, Co. Wicklow. A98 V6P2
t: (01) 268 8656 www.blackbirdclinic.ie

New patient application form (Adult)

First Name:	Surname:
Date of Birth:	
Address: Eircode:	
Phone number:	Mobile number:
Email:	Gender:
Are you independently mobile? YES NO	Language(s) spoken: (If not fluent in English. Please note we unfortunately have **NO** capacity to provide translators)
Do you have a medical card? YES NO	If YES, Medical Card number: _____ Please ensure you complete the *Medical Card/GP Visit Card Change of General Practitioner (GP) Form*.
Where certain health services are available to you free of charge (e.g. Cervical Check, Vaccinations for certain groups) we will apply on your behalf. To do this we will need your PPSN. Please insert below: PPSN: _____	
Emergency Contact Name:	Tel: Relationship:
Medical History: *(e.g. Condition, Year diagnosed, Is this condition still an issue? Are you currently under the care of a specialist for this condition?)*	
Current Medications:	
Medication Allergies:	

I consent to Blackbird Clinic using the information supplied above for the purpose of my initial assessment and ongoing medical care.

Name (Please print): _____ Signed: _____

Please use a separate copy of this sheet for every adult involved in this application.

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New patient application form (Children under 16)

First Name:	Surname:
Date of birth:	PPSN:
Medical Card Number (If any.):	
Medical Conditions:	
Current Medications:	
Medication Allergies:	
Parent/Guardian:	

First Name:	Surname:
Date of birth:	PPSN:
Medical Card Number (If any.):	
Medical Conditions:	
Current Medications:	
Medication Allergies:	
Parent/Guardian:	

First Name:	Surname:
Date of birth:	PPSN:
Medical Card Number (If any.):	
Medical Conditions:	
Current Medications:	
Medication Allergies:	
Parent/Guardian:	

I consent to Blackbird Clinic using the information supplied above for the purpose of the initial assessment and ongoing medical care of those mentioned. I confirm that I am authorised to consent on their behalf.

Name (Please print): _____ Signed: _____

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Request of Medical Records

To Dr: _____
_____
_____

Please enter the name and address of your previous GP

Re: _____ Date of birth_____
Re: _____ Date of birth_____
Re: _____ Date of birth_____
Re: _____ Date of birth_____

Please enter your name and DoB as well as those of any other persons involved in this application.

Address:_____

Dear Doctor,

The above patient(s) have decided to register with us.

I would be grateful if you could send us a copy of their medical records. A signed patient consent in accordance with General Data Protection Regulations has been provided below.

To securely transfer patient files electronically, our HealthMail address is: Blackbirdclinic.GP@healthmail.ie

Yours sincerely,

_____

Dr. John Kealy,
MCRN: 409271

Patient Section

Date: _____

I _____ (PRINT NAME)

Consent to the release of the medical records to Blackbird Clinic on behalf of myself and any others listed above. I confirm that I am authorised to request the transfer of those listed above.

_____

Signature of Patient (or Guardian)

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Text Messaging Consent Form

From time to time, Blackbird Clinic may wish to contact you by text – for example to remind you about an upcoming appointment or to inform you that your test results are back.

Please read the notes below carefully before you sign below to give or withhold your consent

- Test messaging is a one-way service. There is no reply facility to enable patients to send text messages back to the practice. If you wish to communicate with staff please either make an appointment, call 0404 31551 or send in a written request.
- Text messages are generated using a secure facility. They are transmitted over a public network onto a personal mobile phone and so may not be secure. However, we will only send text messages to let you know that your results are normal or to ask you to contact us. You may also receive important personal healthcare reminders such as availability of the flu vaccine, or that your baby's immunisation are due. Private medical results or information will never be communicated via text message.
- Text reminders will not be routinely sent for all appointments. The responsibility of attending and cancelling appointments rests with you.
- We advise that you password protect your phone, read and then delete GP texts.
- If your mobile number changes or you lose your mobile phone, it is your responsibility to let us know your new mobile number.
- You can of course cancel the text message facility at any time by calling us on 01 268 8656 or by sending in a written notification.
- Please also be aware that it is practice policy not to communicate with patients via email except for provision of electronic copies of receipts.

- Please remember it is important to advise us if your contact details change. If you don't let us know your mobile number or email address has changed we may inadvertently send information to an incorrect person.
- I agree to updating the practice if my contact details change please tick box ☐

☐ I Consent to: ☐ I Do NOT Consent to:

Blackbird Clinic contacting me by text message for patient care and appointment reminders. This includes any children under my guardianship.

☐ I Consent to: ☐ I Do NOT Consent to:

Blackbird Clinic contacting me by text message in relation to Investigation results. . This includes any children under my guardianship.

Signature: _____ Date: _____

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Patient Data Consent Form

An Roinn Tithíochta,
Rialtais Áitiúil agus Oidhreachta
Department of Housing,
Local Government and Heritage

Department of Employment Affairs and Social Protection

Data Consent Form

Name: _____

PPSN: _____

Date of Birth: _____

I the undersigned, authorise Blackbird Clinic to transfer my personal data for the purpose of claiming and proving eligibility to illness/Disability Schemes to the Department of Employment Affairs and Social Protection. My consent remains valid for all future transactions with the Department unless I revoke it in writing.

I understand that I may revoke this consent at any time by contacting the Department or by informing the medical practice in writing.

Signature of Patient: _____

Signature on behalf of Blackbird Clinic: _____

Date: _____