THE PALL MALL SURGERY
SYSTMONE ACCESS

Application for registration to use SystmOne an online service to:

- Request a repeat prescription
- Notify a change of home address
- Access Medical Record Viewer

NAME:

DATE OF BIRTH:

ADDRESS:

HOME TELEPHONE NUMBER: **MOBILE NUMBER :**

EMAIL ADDRESS:

SIGNATURE:

DATE:

CONSENT TO RECEIVE SMS TEXT MESSAGES : YES / NO

PLEASE BE INFORMED THAT IF YOU DO NOT PICK YOUR PIN NUMBER UP WITHIN 10 DAYS OF IT BEING PROCESSED IT WILL EXPIRE AND YOU MIGHT HAVE TO RE-APPLY.

To use this service you require a PIN. Patients over the age of 13 will each receive their own pin. Children under the age of 13 will be given access via their parents pin. Please allow one week for us to complete your request and generate a PIN for you. We will contact you when ready for collection. Can you please attend for collection between the hours of 1400 and 1600 hrs. Monday to Friday. You will need to bring proof of identity when you collect your PIN, this MUST include photo ID. **No one else is able to collect the PIN for you**. All details of how to use the service will be provided with your PIN.

CHILDREN 13 YEARS AND OVER. You are able to register to use this service for your children, although this will be reviewed when your child becomes 13 years old. At that age we will contact the young person and ask whether they would like to register for themselves or continue to allow their parent / guardian to access this service on their behalf. If the child agrees for the parent / guardian to continue to have access we will request annual consent until the patient becomes 18 years old when the access by the parent / guardian will automatically cease and the 18 year old will need to register to use the service him/herself.

If this request is for a young person between the ages of 13 and 18 and the parent / guardian is requesting the access for the online service would the young person please sign the declaration below.

I give consent for my parent / guardian (please name)…… to have access to book / cancel appointments, order repeat prescriptions and have access to my medical records on my behalf. I understand I can cancel this arrangement at any time.

Signed: Date: Office Use Only
Document produced :

Please Print Name: Staff Name :