Summary Care Record FAQ

What is a summary care record?

Summary care record (SCR) is an electronic summary of key clinical information about each patient registered with the NHS in England. The information held in a summary care record gives registered and regulated healthcare professionals, away from the patient's usual GP practice, access to information to provide safer care, reduce the risk of prescribing errors, and improve the patient experience.

What information is included in a summary care record?

There are two types of summary care records. See the table below to see the information held in each summary care record.

Information	Core SCR	SCR with additional information
Name and address	•	•
Date of birth	•	•
NHS number	•	•
Current medications (repeat and acute)	•	•
Allergies and adverse reactions	•	•
Discontinued repeat medication	•	•
Significant medical history		•
Health conditions		•
Carers details		•
Treatment preferences		•
Anticipatory care information		•
Reasonable adjustments		•
Tests, scans and x-ray results		•
Specialist care		•
Immunisations		•
Lifestyle information		•
Urgent provision of care		•
Hospital admission/discharge information		•
COVID-19 information		•

What sensitive Information is stored?

Sensitive information is excluded from all versions of the SCR. This includes information such as fertility treatment, pregnancy terminations, gender reassignment and sexually transmitted diseases.

For more information on summary care records, please visit Summary Care Records (SCR) - information for patients - NHS Digital