**NEW COURT SURGERY**

**Please bring the child’s Red Book with you so we can take a copy of their immunisation record.**

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| --- |
| **CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)** |
|  |
| **Child’s Personal Details:** |
|  |

**Please complete all pages in FULL using BLOCK capitals**

|  |  |
| --- | --- |
| Child’s Surname: |  |
|  |  |
| Child’s First Names (in full): |  |
|  |  |
| Previous Surnames: |  |
|  |  |
| **Title:** | ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female |
|  |  |
| Date of Birth (day/month/year): |  |  |  |  |  |  | NHS Number:(if known) |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Town & Country of Birth: |  |
|  |  |
| Address: | Post Code:  |
|  |  |
| Telephone Number: |  | Mobile Number1: |  |
|  | 1  Note, we use the mobile number for text messages.Text messages will automatically cease when the Child is 11 years old. |
|  |  |  |  |
| Email Address2: |  |
|  |  |
| 2  Please specify whose above email address this is, e.g. parent, guardian etc. |  |
|  |  |
| **Name of Parent(s) / Carers** | **Has Legal / Parental Responsibility?** | **Next of Kin?** |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
| 1.
 |  ❒ Yes ❒ No |  ❒ Yes ❒ No |
| If not the above, name of person with legal responsibility: |  |
| Contact details of person with legal responsibility |  |
|  |  |
| **Does the child have any special communication / mobility needs?** ❒ Yes ❒ No**If yes:** ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print  ❒ Lip Reading ❒ Braille ❒ British Sign Language  ❒ Makaton Sign Language ❒ Other: ….………………………………….. |
|  |
| **Is the child currently:** ❒ A Refugee ❒ An Asylum Seeker**Is the child a child in care?** ❒ Yes ❒ No**Is the child a “Looked After Child”?** ❒ Yes ❒ No**If yes to either of the above questions, in what capacity?** ❒ Temporary ❒ Permanent**Is the child home educated?**  ❒ Yes ❒ No Name of Social Worker: …………………………………………………………………………………………Social Worker’s Phone No: ………………..……………………………………………………………………….Name of child’s nursery/school ……………..………………………………………………………………………. |
| **Has the child or family either currently or in the past been known to Children’s Services?**❒ Yes ❒ NoName of Social Worker: …………………………………………………………………………………………Social Worker’s Phone No: ………………..………………………………………………………………………. |
|  |
| **Required Information:** |
|  |

Is your child looking after someone at home? ❒ Yes ❒ No

|  |  |
| --- | --- |
| If so, who3? |  |

3  Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

|  |  |
| --- | --- |
| What is the adult’s relationship to the child? |  |

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

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| --- |
|  |

Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

|  |  |
| --- | --- |
| **If yes,** please provide carer’s name: |  |
| Carer’s relationship to child: |  |
| Contact details of carer: |  |

Are Children’s services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) ([**S.66 Children Act 1989**](http://www.legislation.gov.uk/ukpga/1989/41/section/66))  is placed for 28 days or more in the care of someone who is not the child’s parent(s) or a ‘connected person’. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative**as defined under the [**Children Act 1989, section 105**](http://www.legislation.gov.uk/ukpga/1989/41/section/105):*‘A relative under the Children Act 1989 is defined as a ‘grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent’.*

|  |
| --- |
| **Please help us trace the child’s previous medical records by providing the following information:** |
|  |
| Your previous address in the UK: | Post Code:  |
|  |  |
| Name of previous Doctor while at that address: |  |
|  |  |
| Surgery Name and Address of previous Doctor: | Post Code:  |
|  |  |
| **If you are from abroad:** |
|  |
| Your first UK address where Registered with a GP: | Post Code:  |
|  |  |
| If previously resident in UK date of leaving: |  | Date you firstcame to the UK: |  |

|  |
| --- |
| **If registering a child under 5:** |
|  |

❒ I wish the child above to be registered with New Court Surgery for Child Health Surveillance

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

**For Dispensing Practices only:**

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

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| **Patient Declaration for all patients who are not ordinarily resident in the UK:** |
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Please see appendix 1 for patient declaration (last page of form)

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| **Child’s Personal Medical History:** |
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| If under 5 years old, type of Birth: *(eg normal, forceps, caesarean)* |  |
|  |  |

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year Diagnosed** | **Ongoing** |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

|  |
| --- |
| **Family Medical History:** |
|  |

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Heart Disease** | **Stroke** | **Diabetes** | **High Blood Pressure** | **Asthma** | **Glaucoma** | **Cancer** | **Mental Health Problems** | **Renal/ Kidney** | **Learning Difficulties** |
| **At the time of diagnosis they were:** |
| **Over****60 yrs old** |  |  |  |  |  |  |  |  |  |  |
| **Under** **60 yrs old** |  |  |  |  |  |  |  |  |  |  |

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| **Child’s Immunisations:** |
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Please provide details of your child’s immunisations with dates if possible (under 5’s). If possible please give your Red Book to Reception to photocopy:

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

|  |
| --- |
| **Child’s List of Current Medication:** |
|  |
| **Name of Medication**  | **Dosage** |
|  |  |
|  |  |
|  |  |
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| --- |
| **Child’s Allergies:** |
|  |

Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

|  |  |
| --- | --- |
| **Name of Medication**  | **What was the problem or upset?** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Child’s Ethnicity:** |
|  |

❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani

❒ Bangladeshi ❒ Chinese ❒ Other (please state):

❒ Decline to state

|  |
| --- |
| **Child’s Religion:** |
|  |
| Please state religion of child: |  |

Please advise if you feel your child’s religion will affect any treatment received: ❒ Yes ❒ No

|  |
| --- |
| **Child’s Language:** |
|  |
| Please state child’s main spoken language: |  |

Does the child need an interpreter? ❒ Yes ❒ No

|  |
| --- |
| **Data Sharing Consent Choices:** |
|  |

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email ❒ Yes ❒ No This will be to send you letters, the practice newsletter and the like

By text ❒ Yes ❒ No This will be to send you information relating to appointments via text

|  |
| --- |
| **Signatures:** |
|  |

I confirm that the information that has been provided is true to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

Signature on behalf of patient ❒ Signature of patient ❒

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person |  | Relationship to Child: |  |

|  |
| --- |
| **Box for extra details:** |

|  |
| --- |
|  |

Updated 26/09/17 Appendix 1

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| **PATIENT DECLARATION for all patients who are not ordinarily resident in the UK** |
|  |
| **Patient’s Details** | *Please complete in BLOCK CAPITALS and tick* ***✓*** *as appropriate* |
|  |  |
| ❒ Mr ❒ Mrs ❒ Miss ❒ Ms  | Surname: |  |
|  |  |  |
| Date ofBirth |  |  |  |  |  |  |  | First Names: |  |
|  |  |  |  |  |  |  |  |  |  |
| NHSNo. |  |  |  |  |  |  |  |  |  |  |  | PreviousSurname/s: |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ❒ Male ❒ Female  | Town andCountry of Birth: |  |
|  |  |  |
| Home Address: |
|  |
| Postcode:  | Telephone No:  |

****

**Scan and send this page of form to:** NHSDigital-EHIC@nhs.net

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.