CHILD REGISTRATION FORM

THIS PAGE IS FOR OFFICE USE ONLY

ADMIN CHECKLIST:

- ☐ Have all areas of the form been completed by the patient's carer?
- ☐ Have you informed the patient's carer that they need to ensure their current Practice has issued then with 1 month's supply of any medication to cover them for the registration period?
- ☐ Have you asked the patient's carer if they would like to be signed up for System online proxy access? If yes, ensure they have completed the box on page 4.
- ☐ Have you asked the patient's carer if they would like to nominate a pharmacy? If so, please ensure they have filled out the relevant box on page 6
- ☐ Have you ensured the patient's carer understand our prescription time process is 48 hours?

FOR OFFICE USE ONLY

Date:_____ **Staff Initials:** _____

PHOTO ID ☐ **TYPE:** _____ **ADDRESS ID** ☐ **TYPE:** _____

(Aged 16 and over only)

GP services – Patient Registration Form (Children)

Thank you for applying to join *Central Surgery - Oadby*. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care. **You may need to supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENSE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.
Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s) (if applicable)	*Date of Birth DD / MM / YYYY
* ☐ Male ☐ Female	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address
*Home telephone No.	*Postcode
Work telephone No.	
*Mobile No. (if you have one)	Email address

Please help us trace your previous medical records by providing the following information

*Previous address in the UK (if applicable) Postcode	Name of previous doctor Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP if you were previously living abroad Postcode	*If previously a resident in the UK, date of leaving *Date you first came to live in the UK (if applicable)

If you are returning from the Armed Forces

Address before enlisting Postcode	Service or Personnel No. Enlistment date:

If you are registering a child under 5

I wish the child above to be registered with the doctor named for Child Health Surveillance ☐

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child

Who has the legal responsibility for the child? ☐ You as the legal parent or guardian ☐ **Other** (please specify) _____	Who can consent for the medical treatment for the child? ☐ You as the legal parent or guardian ☐ **Other** (please specify) _____

Looked after Children

Are you looking after someone else's child? ☐ Yes ☐ No
If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order ☐ Child arrangement order/Residence Order
☐ Special Guardianship order ☐ Placed for adoption ☐ Private arrangement/Private Fostering/informal arrangement
(please note you have a duty to notify social care of this arrangement)

Donor Registration Choices

NHS Organ Donor Registration
"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

NHS Blood Donor Registration
I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.
☐ Yes I give consent to be included on the NHS Blood Donor Register

Tick here if you have given blood in the last 3 years ☐
For more information, please ask for the leaflet on joining the NHS Blood Donor Register My preferred address for donation is: (only if different from above, e.g. your place of work)

……., Postcode: ……..

Additional details about you

What is your ethnic group?

White	☐ British	☐ Irish	☐ Other White (please specify):	
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):	
Asian	☐ Indian	☐ Pakistani	☐ Other Asian (please specify):	
Mixed	☐ White & Black Caribbean		☐ White & African	☐ White & Asian

Information and Communication Needs

*Do you have any communication or information needs due to disability, impairment or sensory loss? (if yes please specify)

*Communication or information method required i.e. braille; email

Carer/Next of Kin Relationship Information

Do you have a Carer? ☐ Yes ☐ No Their contact details:

Do you consent for your carer to be informed about your medical care? ☐ Yes ☐ No

Are you a Carer? ☐ Yes ☐ No

If yes, do you look after someone who is a patient of *Central Surgery – Oadby*? ☐ Yes ☐ No ☐ Don't know

If yes, what is their name? Are they a: ☐ Relative ☐ Friend ☐ Neighbour

Name of next of kin	Relationship to you

Next of kin telephone number(s)	Next of kin address (if different to above)

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

Medical Details and Lifestyle Habits

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of

Have you ever had any of the following conditions?

Epilepsy	☐ Yes	Year	**Rheumatoid Arthritis**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Mental Illness (Inc. Depression)**	☐ Yes	Year
Heart Attack	☐ Yes	Year	**Diabetes (type 1 or type 2)**	☐ Yes	Year
Angina (stable / unstable)	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Transient Ischaemic Attack	☐ Yes	Year	**Osteoporosis / Bone Fractures**	☐ Yes	Year
Cancer	☐ Yes	Year	**Peripheral Vascular Disease**	☐ Yes	Year

List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place

Do you have family history of any of the following?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs.	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs.	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who
Diabetes	☐ Yes	Who	**Other (Please list)**		Who

Height	ft.	in
Weight	St.	lb
Waist measurement	in	

(**for women only**) Have you had a cervical smear? ☐ Yes ☐ No
(*Please state where, when and the result if possible*)

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No

If Yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe / VAPE **(please circle)**

How many do you smoke a day?

Would you like advice on quitting? ☐ Yes ☐ No

Are you an ex-smoker? ☐ Yes ☐ No

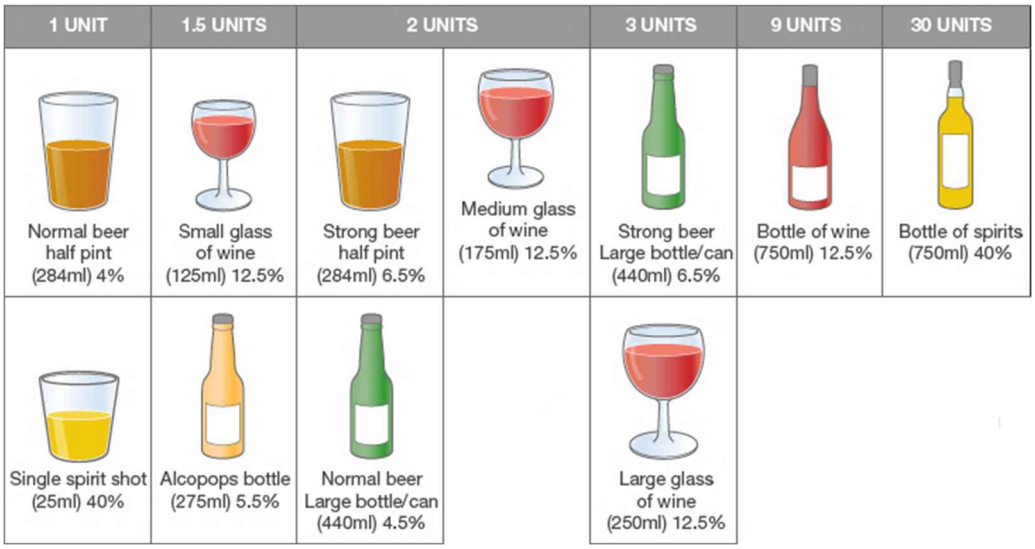
When did you quit?

How many did you used to smoke a day?

Please tell us about your alcohol consumption

Questions (please circle your answers in the boxes below)	**Unit scoring system**				
	0	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 4 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.



Communication Preferences

*Do you consent to receive the following types of communication from *Central Surgery – Oadby?*

Email ☐Yes ☐No

Mobile phone text messages ☐Yes ☐No

Answering machine messages ☐Yes ☐No

Letter ☐Yes ☐No

GP Online Services – Patient Online Proxy Access

Once your application to join our practice has been accepted you'll be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **Patient Access**.

Once you are a fully registered patient of our practice you can visit *https://thecentralsurgeryoadby.co.uk* to begin your Patient Access registration. This service is available to everyone with a valid email address. ***We can only accept your request for Patient Access if your email address is valid and not shared by another person.***

Would you like to use Patient Access? ☐ Yes ☐ No

If yes, please specify the e-mail address you wish to use for GP Online access _____

When your application to join the practice has been processed we will post to you your **Patient Access** details.

Data Sharing

Electronic Data Sharing Module (EDSM)

Healthcare places can usually share information from your records by letter, email, fax or phone but this can slow down your treatment or mean information is hard to access. However you can choose to share your record electronically between care services. **For more information please visit our website at** *https://thecentralsurgeryoadby.co.uk*

Tick this box if you wish to opt-in to the EDSM ☐

Tick this box if you wish to opt-out to the EDSM ☐

Summary Care Record (SCR)
As you are registering with this practice, we would like to recommend that you take advantage of the Summary Care Record (SCR). It includes important information about your health: Medicines you are taking; allergies you suffer from, any bad reactions to medicines

You can also choose to have additional information included in your SCR, which can improve the care you receive. This information includes: Your 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; who should be contacted for more information about you

You may need to be treated by health and care professionals outside of the practice who do not know your medical history. Having the additional information SCR can help the staff involved in your care access information more quickly, allowing them to make informed decisions about your healthcare. **More information can be found by visiting www.nhscarerecords.nhs.uk**

Tick this box if you wish to opt-in to the Core SCR ☐

Tick this box if you wish to opt-in to the Core an Additional SCR ☐

Tick this box if you wish to opt-out of the SCR ☐

Medical Interoperability Gateway (MIG)
Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.
For more information please visit the Sharing Your Medical Record page on our website at *https://thecentralsurgeryoadby.co.uk*

Tick this box if you wish to opt-out of the MIG ☐ **Tick this box if you wish to opt-in of the MIG** ☐

Once you are registered…

Electronic prescribing service (EPS)
You will be able to nominate a pharmacy to collect your prescriptions, EPS enables prescribers, such as GP's and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen.
I would like my prescription sent electronically to:……..

Please record any additional information about you that you think is important for us to know

***Signed**

***Date** DD / MM / YYYY

***Signed on behalf of patient** (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)