New Patient Registration Form - Child

Please complete all pages in full using block capitals and black ink.

1. Background Details

Your Child's Details			
Child's First Name(s)		Child's Surname	
Address		Gender	
		Date of Birth	

Parent or Guardian Details			
Main Carer Name		Relationship	
Address		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted by SMS on this number:		
Email	I consent to be contacted by email at this address:		
Preferred Contact Method	(circle only one option) Letter / Email / SMS		
Language	What is your main spoken language if not English?_____ Do you need an interpreter? ☐ Yes ☐ No		
Name of person with parental responsibility (if different to main carer)	Name:	Tel:	Relationship:
Next of Kin (if different to main carer)	Name:	Tel:	Relationship:

** It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results, health campaigns or Patient Participation Group details*

Communication Needs	
Language	What is the child's main spoken language if not English?_____ Do they need an interpreter? ☐ Yes ☐ No
Communication	Do they have any communication difficulties? ☐ Yes ☐ No If **Yes** please identify below ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog

2. Medical History

Medical History

Has your child suffered from any of the following conditions?

☐ Asthma ☐ Depression ☐ Diabetes ☐ Epilepsy

Any other conditions, operations or hospital admission details:

If your child is currently under the care of a Hospital or Consultant outside our area, please tell us here:

Any developmental problems, please provide details:

Family History

Please record any significant family history of close blood relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma……..	☐ Heart Disease……	☐ Diabetes……..……	☐ Depression……..……
☐ COPD……...…	☐ Stroke…….……..	☐ Kidney Disease..……	☐ Thyroid……..……...
☐ Epilepsy……	☐ Blood Pressure……	☐ Liver Disease..…..……..	☐ Cancer……..

Other:

Allergies

Please record any allergies or sensitivities below

Current Medication

Please check and include as much information about your child's current medication below
If they have a previous repeat medication list please give this to us & they may need a medication review appointment

3. Other

Other Details				
Household details. Please list all those who live at the address (name, date of birth and relationship to child)	Name:	DOB:	Relationship:	
	Name:	DOB:	Relationship:	
	Name:	DOB:	Relationship:	
	Name:	DOB:	Relationship:	
	Name:	DOB:	Relationship:	
	Name:	DOB:	Relationship:	
Name of School (If applicable)				
Ethnicity of Child	☐ White (UK) ☐ White (Irish) ☐ White (Other)	☐ Black Caribbean ☐ Black African ☐ Black Other	☐ Bangladeshi ☐ Indian ☐ Pakistani	☐ Arabic ☐ Chinese ☐ Other
Religion of Child	☐ C of E ☐ Catholic ☐ Other Christian	☐ Buddhist ☐ Hindu ☐ Muslim	☐ Sikh ☐ Jewish ☐ Jehovah's Witness	☐ No religion ☐ Other:
Housing of Child	☐ Own Home ☐ Rented Home	☐ Shared House ☐ Sheltered House	☐ Asylum Seeker ☐ Refugee	
Overseas Visitor	☐ Yes	☐ European Health Insurance Card Held (please bring details with you)		
Armed Forces	☐ Family Member			

Smoking
Are there any smokers living at the address ☐ Yes ☐ No

Any Other Information
Please inform us of any other matters that you feel are relevant to the care of this child

4. Sharing Your Health Record (see following sheet for further information)

Your Health Record

Do you consent to your GP Practice sharing your Child's health record with other organisations who care for them?

☐ Yes *(recommended option)*
☐ No

Do you consent to your GP Practice viewing your Child's health record from other organisations that care for them?

☐ Yes *(recommended option)*
☐ No

Your Summary Care Record (SCR)

Do you consent to your child having an Enhanced Summary Care Record with Additional Information?

☐ Yes *(recommended option)*
☐ No

Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

Bottisham Medical Practice will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records

For further information about how the NHS uses your data for research & planning and to opt-out, please see:

www.nhs.uk/your-nhs-data-matters

5. Signature and Checklist

Parent or Guardian Signature	
Signature	I confirm that the information I have provided is true to the best of my knowledge
Name	
Date	

Checklist
Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed & Signed New Patient Registration Form
- ☐ Completed & Signed GMS1 Form
- ☐ Birth Certificate

Practice Use Only

Appointment Required	☐ Yes (Date_____Time_____Dr_____)	☐ No		
Birth Certificate	☐ Yes	☐ No		
Preferred Contact Method Selected	☐ Yes	☐ No (if no ask Pt/carer to confirm)		
Ensure no conflict in contact consents	☐ checked (if there are please clarify with Pt/carer)			
GMS1 Completed inc	☐ NHS Number	☐ Place of Birth	☐ Previous Address	☐ Previous GP
Form Taken in by	Initials	Date		