**LOCKSWOOD SURGERY - NEW PATIENT REGISTRATION FORM**

**Children and Young People aged 0 – 16 years old**

Welcome to Lockswood Surgery. Please complete the following forms on behalf of the child. This information is extremely valuable to assisting us in providing you with the high standard of care we pride ourselves on offering to our patients.

At Lockswood Surgery a receptionist will be happy to assist you with any queries you may have. Bring the forms with you along with suitable identification. Acceptable identification documents are shown in the list below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **IDENTIFICATION** | | | | | |  |
| Bank statement | |  | Letter-Social services | | |  |
| Birth certificate / Adoption certificate | |  | Passport | | |  |
| Letter-Benefits Agency/benefit book | |  | Red book | | |  |
|  | |  |  | | |  |
| **Any of the above documents can be accepted as identification.** | | | | | | |
| **For office use only** | | | | | | |
| **Name confirmation** Which document was seen? |  | | | **Date of document:** |  | |
| **Address confirmation** Which document seen? |  | | | **Date of document:** |  | |
| **Staff member** (write clearly) |  | | | **Today’s date:** |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ABOUT YOUR CHILD** | | | | | | | |
|  |  | |  |  |  | | |
| **Surname**: |  | |  | **Forename(s)**: |  | |  |
|  |  | |  |  | |  | |
| **Gender:** |  | |  | **DOB**: |  | |  |
|  |  | |  |  | |  | |
| **Address**: |  | | | | | |  |
|  |  | | | | | |  |
|  |  | |  | | | | |
| **Post code**: |  | |  | | | | |
|  |  | | |  |  |  | |
| **Home Phone**: | |  | **Work Phone:** | |  | |  |
|  |  | | | | |  | |
|  |  | | | | | |  |

**Does the child have a carer?** Yes  No

**\* \* \***If you answered YES to this question, please ask a receptionist for a CARER FORM**\* \* \***

|  |  |  |  |
| --- | --- | --- | --- |
| **ABOUT PARENT / GUARDIAN** | | | |
|  | |  | |
| Who has legal parental responsibility? (I.e. both parents, mother, father, grandparents, other)? | | |  |
|  |  | |  |
|  | | |  |
| Who does the child live with? | | |  |
|  |  | |  |
|  | | |  |
| Which school does the child attend? | | |  |
|  |  | |  |
|  | | | |
| Are there any issues at school or home that we need to know about? | | | |
|  |  | |  |
|  | |  | |

**COLLECTING INFORMATION ABOUT ETHNIC GROUPS**

**Under the terms of the NHS Contract, the Practice is required to ask all new patients to describe their own ethnic group.** This list is designed to allow most people to identify themselves. However, if you feel the categories do not describe your ethnic group, please let us know and we will enter ‘any other group’ together with details of how you would describe yourself (e.g. ‘Cornish’).

The reasons given for collecting this data are that ‘information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.’.

If you choose not to complete the question we will assume that you have exercised your right to refuse to divulge your ethnicity.

**Ethnic Groups**

Please tick:

|  |  |  |
| --- | --- | --- |
| Asian or Asian British – Indian | Asian or Asian British – Pakistani | Asian/Asian British – Bangladeshi |
| Asian/Asian British – any other Asian background | Black or Black British – Caribbean | Black or Black British – African |
| Black or Black British – any other Black background | Chinese | Mixed – White and Black Caribbean |
| Mixed – White and Black African | Mixed – White and Asian | Mixed –any other mixed Background |
| White – British | White – Irish | White – any other White background |
| Any other ethnic group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language(s) Spoken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | |

**Collecting information about Service Families**

Lockswood Surgery recognises its responsibilities to the families of Armed Forces Personnel. We need to know if your child is a member of a Service Family so that, if necessary we can inform other healthcare providers so that your child is not disadvantaged by having to move locations with their parents or guardians because of the needs of the Service.

Is your child a member of a Service Family? (13WY)  Yes  No

Is your child on a waiting list in another place?  Yes  No

Which waiting list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Which Hospital/Referral Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FORM FOR SERVICES – PLEASE READ CAREFULLY**

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| --- |
| **Access to Online Services**  Do you have access to the internet (Smart Phone, Laptop or Personal Computer)?  If so, you can request proxy access to your child’s services using your own Online Service  You can book appointments for doctors  Also, you can order Repeat Prescriptions, find out more about your care, – all in one place!  **If you have provided us with an email address, we will automatically enrol your child onto EMIS Online.**  If you **DO NOT** want your child to be enrolled on EMIS Online please tick this box here  **Once your child reaches 16 years of age, any shared access will be discontinued and your child will need to re-apply themselves** |

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| --- |
| **Phone Messages, Email & Text Messaging Services**  To make life a little easier, we can leave messages on your phone either at home or on your mobile. You should be aware that your messages may be picked up by another person at home or if you don’t keep us informed of a number change. We will **NEVER** leave personal or medical information in a message.  Many people find it useful to have important messages sent to them via email and/or text messages.  At Lockswood Surgery , we use texts and emails to keep you informed about your child’s appointments, important events such as Flu Vaccination Clinics and if there are issues & news about the practice (such as a power failure or illnesses).  **If you have provided us an email address and or a mobile phone number, we will automatically enrol your child onto our email and text messaging service.**  If you **DO NOT** want to receive telephone messages, please tick this box here  If you **DO NOT** want to receive text messages. please tick this box here  If you **DO NOT** want to receive emails, please tick this box here  **Once your child reaches 16 years of age, any shared access will be discontinued and your child will need to re-apply themselves** |

|  |
| --- |
| **Summary Care Record and Hampshire Health Record**  These computer based records will be automatically created for your child when you register them. They contain health information about you such as medications, allergies etc. The Summary Care Record can be viewed by appropriate clinical treating your child throughout England in A&Es, Ambulance Services, other GP surgeries and out of hours providers.  The Hampshire Health Record is a more detailed summary that can only be viewed by appropriate clinical staff treating your child in Hampshire in similar circumstances.  **We will automatically enrol your child onto the Summary Care Record and Hampshire Care Record**  If you **DO NOT** want to share your child’s information using the Summary Care Record,  please tick this box here  If you **DO NOT** want to share your child’s information using the Hampshire Health Record,  please tick this box here  **(sorry, but we’ll need you to fill in another form!)** |

**NEXT OF KIN NOMINATION**

|  |  |  |
| --- | --- | --- |
| **CHILDS 1st NEXT OF KIN** | | |
|  |  | |
| **Name:** |  |  |
|  |  | |
| **Relationship to you:** |  |  |
|  |  | |
| **Telephone:** |  |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| **CHILDS 2nd NEXT OF KIN** | | |
|  |  | |
| **Name:** |  |  |
|  |  | |
| **Relationship to you:** |  |  |
|  |  | |
| **Telephone:** |  |  |
|  |  | |

**YOUNG CARERS**

**IS YOUR CHILD A YOUNG CARER?** Yes  No

(*do they look after someone who is dependent on them some, or all of the time?*)

**\* \* \*** If you answered YES to this question, please request a Carers Form when you hand in this completed form**\* \* \***

**REPEAT PRESCRIPTIONS**

**Does your child have regular repeat prescriptions?**

If so, by signing up to Online Services, you can request their repeat prescription from home, work or anywhere you have access to the internet. We can also take repeat prescription requests by email, phone, fax or written request.

**Nominate a pharmacy**

Did you know that you can have ALL your child’s prescriptions sent electronically to a pharmacy of your choice?

If you tell us which pharmacy you would like to use here, we can arrange this for you.

By asking us to do this, you won’t need to collect the child’s prescriptions from reception

I would like to nominate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy, \_\_\_\_\_\_\_\_\_\_\_\_\_ Branch \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD’S MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **IMMUNISATIONS** | | | | | |
|  | **If you have any concerns about your child’s vaccinations, please book an appointment with one of our practice nurses** | | | |  |
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| --- | --- | --- |
| **ALLERGIES** | | |
| |  |  |  | | --- | --- | --- | |  | Yes | No | | Has the child ever had an allergic reaction to a vaccine resulting in a rash, difficulty breathing, swelling or collapse? |  |  | | Is your child allergic to eggs? |  |  |   Please list any drugs or substances (e.g. nuts, eggs) that the child is allergic to (i.e. develops rash/swelling/anaphylactic shock – not side effects such as diarrhoea or nausea). | |  |
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| --- | --- | --- | --- | --- | --- | --- |
| **HEALTH** | | | | | | |
|  | | Has the child ever been diagnosed with: | | **Yes** | **No** |  |
|  | | Asthma |  |  |  |  |
|  | | Epilepsy |  |  |  |  |
|  | | Diabetes |  |  |  |  |
|  | | Deafness/hearing impairment | |  |  |  |
|  | | Blindness/visual impairments | |  |  |  |
|  | |  |  |  |  |  |
| **Please give information about any of the following that the child suffers from**: | | | | | | |
|  | | | | | |  |
|  | Learning/behavioural difficulties | | | | |  |
|  |  | | | | |  |
|  | | | | | |  |
| Heart/Lung/Kidney/Liver problems | | | | | |  |
|  |  | | | | |  |
|  | | | | | |  |
| Other medical problems | | | | | |  |
|  |  | | | | |  |
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| --- |
| **MEDICATIONS** |
| Please provide a list of repeat medications (if possible, attach a repeat card to this form (we can photocopy it for you) |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/20\_\_