**Under 18 Patient Registration Form**

**Dr Jain & Dr Subramanian**

Surname:………………….First name:……………..Date of Birth:…………….

Current Address:………………………………............................... Home Tel:…………………….

……………………………….................Post Code……………..

Previous Address:………………………………............................... Home Tel:…………………….

……………………………….................Post Code……………..

Mobile Number:……………………….. Home Number: ………………………..

Ethnicity……………………… Sex:…M / F… NHS number:…………………….....................

Main Spoke Language…………………….

Child’s Current School/Nursery…………………..

**General History:**

Does your child have any medical conditions **Y/N** ………………………………………..

Does your child have any additional needs **Y/N** ………………………………………..

Do you consider your child to have a disability **Y/N** ………………………………………..

Does your child take any regular medicines **Y/N** ………………………………………..

Does your child have any allergies **Y/N**………………………………………..

**Family History:**

Which of your child’s blood relations have suffered

from the following:

Heart attack………………… Cancer……………

Diabetes……………….Asthma………………..

High blood pressure……….……....TB…………

Stroke…………. ……Other………………….

|  |
| --- |
| Who else lives in your household with your child? |
| Name | Age/Date of Birth | Relationship to child |
|  |  |  |

|  |  |
| --- | --- |
| List of Vaccinations the child has had | Date given |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
|  | Other Details: |
| Do you have parental responsibility for the child? **Y/N** |  |
| Is the child you are registering “looked after” by the local authority or subject of a child protection plan? **Y/N** |  |
| Is your child a carer for you or someone else? **Y/N**If so, for whom? |  |
| Does the child/your family have a social worker? **Y/N**  Please give name/contact details. |  |
| Do you know the name of you child’s health visitor/school nurse?Please state **Y/N** |  |
| Is there anything else you think the practice needs to be aware of? **Y/N** |  |

**Summary Care Record**

**(Please read all 3 sections and fill in your preference in the box below)**

**Summary Care Record**

* Your summary care record contains important information about and medicines you are taking, any allergies you may have and any bad reactions to medicines you may have experienced previously.
* Allows authorised healthcare professionals to have access to this information will improve decision making by doctors and has prevented mistakes being made when patients are being cared for in a different care setting.
* Your summary care record includes your name, address, D.O.B and your NHS number to help identify you correctly.
* Healthcare staff will have access to this information- so that they can provide safer care whenever or wherever you need it, anywhere in England.

**Enhanced Summary Care Record (recommended for patients over 65 & with complex medical needs)**

We are required to offer to share your enhanced summary care record, this includes all information in the summary care record as well as any significant medical diagnoses, any significant treatments (e.g. immunisations and seasonal influenza dates) and any significant investigations (e.g. Gastroscopy and MRI scans results). If you would to consent to this, then tick in the box below.

**Opt –Out of Summary care Records**

**If you do not wish to consent to Summary care Record and want to opt out, please speak to Reception staff and fill in a form.**

|  |  |  |
| --- | --- | --- |
| Type of Summary Care Record | Level of Consent | **C:\Users\courtney.salmon\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DC22TC6N\Check_mark_23x20_02.svg[1].png**Please select and Tick to Consent  |
| Summary Care record | Express consent for medication, allergies, adverse reactions only |  |
| Enhanced Summary Care record( Additional information) | Express consent for medication, allergies, adverse reactions and additional information |  |
| Opt Out of Summary care Record | Opt out – patient does not want a summary care record. |  |

|  |  |
| --- | --- |
| Name of person completing this form |  |
| Relationship to the child |  |
| Signature |  |
| Date |  |

Please note that all information provided in this form will be kept strictly confidential.

**Allocated Named GP for ALL patients**

Dear Patient,

We are required to allocate every patient with a named GP.

If you would like to know who your named GP is, please speak to reception.

**Please note that although you will be allocated a named GP, you are still able to see ANY GP within the practice.**