***YOUNG PERSON***

(up to Age 16)

**NEW PATIENT REGISTRATION QUESTIONNAIRE**

A COMPLETED PURPLE (GMS1) FAMILY DOCTORS SERVICES REGISTRATION FORM MUST ACCOMPANY THIS QUESTIONNAIRE

IF YOU NEED AN APPOINTMENT IN THE NEAR FUTURE PLEASE RETURN THIS FORM PROMPTLY SO THAT WE CAN REGISTER YOU ON OUR CLINICAL SYSTEM – YOU WILL BE UNABLE TO MAKE AN APPOINTMENT UNTIL THIS IS DONE.

Date Stamp Received

Received by (initials) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID SEEN (state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Named GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Informed by (initials)

**To the Parent/Guardian or Carer:**

We are very pleased that you have decided to register with our Practice. In order to help us locate and request medical records, and to help our doctors and nurses give the young person the best possible care before they arrive, please fill in this registration form as thoroughly as you can.

**PLEASE RETURN COMPLETED FORMS IN PERSON TO RECEPTION BETWEEN 9 – 11a.m. (Mon – Fri).**

**The young person you are registering does not need to be present.**

**Please check you have:-**

**COMPLETED and SIGNED THE PURPLE GMS1 FORM on behalf of the young person.**

Provided 1 form of identification (e.g. passport, birth certificate)

We do need to see the originals but we will not take copies of them.

If you need medication soon you need to have provided us with a Repeat Medication Request slip from

your previous GP or bring us the medication containers.

Signed and Dated this form on Page 3.

* When you return the form our Receptionists will advise you of the young person’s named GP but they may see any of the doctors at the practice.
* Cradley Surgery has a clear catchment boundary. If a person or family live outside this boundary and wish to register at Cradley Surgery they are legally entitled to do so as long as certain criteria can be met. If your address is outside of our catchment area one of our administration team will contact you about registering under that scheme if it is appropriate.
* You will be able to access information about the surgery, the services we provide and our staff on our website [www.cradleysurgery.nhs.uk](http://www.cradleysurgery.nhs.uk). This information is also provided in our brochure – please ask for a copy at reception.

**If you need this form in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 01886 880207 or email** [**cradleysurgery@nhs.net**](mailto:cradleysurgery@nhs.net)

**YOUNG PERSON (UP TO 16 YEARS OF AGE)**

**NEW PATIENT REGISTRATION QUESTIONNAIRE**

Title \_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Previous Surname(s) if applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forename(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred First Name *(if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Sex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a preferred method that you would like us to use to communicate to you or the young person?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEXT OF KIN DETAILS**

Name of Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to the young person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Next of Kin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Does the young person have any specific needs e.g. are they blind, do they need a translator? **Yes**  **No**

If **Yes**, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Previous GP Details**

*Please help us trace your child’s previous medical records by providing the following information*

The **young person’s** Previous Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of previous **doctor** whilst at this address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If the young person is from Abroad**

Their first UK address where registered with a GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If previously resident in UK, date of leaving \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date they first came to live in the UK \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the young person’s ethnicity?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is their first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the young person have any religious or cultural needs that you would like us to record? **YES NO**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are registering a child under 5

I wish the young person in my care to be registered with the practice for Child Health Surveillance

Please complete the form on page 5

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**

Is your child allergic to medicines or anything else? **YES NO**

If yes, please give details

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION**

Please give details of any medication which your child takes (prescribe or otherwise)

Right hand side of green prescription (list of medicaitons) from previous surgery

Patient has provided **YES NO**  - If medications are required within 14 days of registration please alert reception.

Urgent meds request 

**DOES THE YOUNG PERSON LOOK AFTER SOMEONE?** Does the young person look after a family member or friend who has a long term health condition,

disability or addiction and they need help on a regular basis? YES NO

If **Yes**, Are they registered with this practice? YES NO

Their Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Their Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**THIS FORM MUST BE SIGNED BY THE PERSON WITH PARENTAL RESPONSIBILITY FOR THE YOUNG PERSON**

**Your signature (on behalf of the young person) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Registration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ONLINE ACCESS TO PATIENT RECORDS (Consent to proxy access to GP online services)**

Practices are increasingly enabling patients to be able to request repeat prescriptions and book appointments online.

Some patients may wish to access more information online and contractually from 1st April 2015 practices are obliged to assist access to medications, allergies and adverse reactions as a minimum and from the 1st April 2016 access to coded data.

In the case of children up until the age of 11 it is our policy to grant those with parental responsibility access to online appointment booking and prescription management without the signature of the patient. With the Senior Partner’s permission we will grant limited access to parts of the coded medical record.

For young people over the age of 11 and under 16 we require the signature of the patient giving permission unless it is deemed they lack capacity – we will deal with all requests on a case by case basis.

Children over the age of 16 are deemed to be competent adults and must apply for themselves unless they lack capacity.

Please indicate if you would like Proxy Access to your child’s online medical record **YES NO**

If you answer yes to this question you will be sent an application form and further information Form Sent

**Information for New Patients: About your Summary Care Record**

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 share across different healthcare organisations and systems. You may need to be treated by health and care professionals who 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 by used for the benefit of your care.

Your options are outlined below; please indicate your choice. **PLEASE ONLY PICK ONE**

**Express Consent for medication, allergies and adverse reactions only.**

You wish to share information about medication, allergies for adverse reactions only.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9Ndm**

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

You wish to share information about medication, allergies for adverse reactions and further medical information that 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 and who should be contacted for more information about you.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9Ndn**

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

Select this option if you **DO NOT** want any information share with other healthcare professionals involved in your care.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9Ndo**

If you choose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

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

If you need more time to make your choice you should let your GP Practice know.

For more information please

Visit: https://nhs.uk/your-nhs-data-matters

or

speak to your GP Practice

If you are opting out on behalf of another person or a child, their GP Practice will consider this request.

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**HEALTH VISITOR’S COPY OF**

**NOTIFICATION OF CHILD/CHILDREN 0-16 YEARS**

***Please detach this form and send to Health Visitors, Ledbury Community Health Centre***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SURNAME** |  | **FORENAMES** |  | | |
| **DATE OF BIRTH** |  | **SEX** |  |  | |
| **CURRENT**  **ADDRESS** |  | | | | |
| **POSTCODE** |  | **TEL NO** |  | |  |
| **PREVIOUS ADDRESS (**of child) |  | | | | |
| **PREVIOUS GP**  **NAME AND ADDRESS** |  | | | | |
| **MOTHER’S SURNAME** |  | **MOTHER’S FORENAMES** |  | | |
| **MOTHER’S DOB** |  | **MOTHER’S NUMBER** |  | | |
| **PLACE AND LOCATION OF CHILD’S BIRTH** |  | | | | |

ADMINISTRATION USE ONLY

**REGISTRATION**

1)  SCR form completed actioned \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *initials*

SCR form **NOT** completed

2)  Proxy Access Request  Form Printed/Sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *initials*

3) 67Dj Named GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *initials (todays date )*

Dispensing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*initials*

Preferred Name check

Next of Kin link in Registration module and entry in Additional Notes on Registration

Specific Needs – if Yes code 13oB  add alert to record

Religious or cultural needs to record YES  NO

Patient Registered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*initials*

OOA Patient  Y  N if Y has PD agreed  - Task to PD

Patients with same name  Y  N if Y has alert been actioned

check children are in same household as adults.

ADOPTED/FOSTER CHILD – check telephone numbers are those of registered guardian

Proxy access requested N  Y actioned

Cradley dispensary (medication-EPS nominated-Dispensing Dr- Set- OK)  or task to nominate

**NPQ TEMPLATE**

Language

Ethnicity

Allergies YES Code record Adverse…….  N/A

NPQ Template Run \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*initials*

**Once registration NPQ template Run**