**The Belgravia Surgery (2022-2023 Version)**

**Today’s Date**

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| **1** | **Full Name:** | | | | **Telephone Number:** | |
| **Title : Master** | | **Miss** | | **Mobile tel. number:**  We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive messages from us: | |
| **Other.** *Please state* **:** | | | |
| **NHS number if known:** | | | |
| **Address:**  **Postcode:** | | | | **E-mail address:** | |
| **Next of Kin:** | |
| **How would like us to contact you about your child:**  **Letter  Email**  **SMS (text)  Phone** | | | | **Next of Kin Relationship to child:** | |
| **Next of Kin contact tel. number:** | |
| **Date of Birth:** | **Gender: Male**  **Female** | | | **Mothers name if different:** | |
| **Town\* and Country of birth Country: Borough (\*If born in London):**  **(\*If town is London please state which Borough) Town:** | | | | | |
| **Please list other residents of your home who are registered with us:** | | | **Name:** | | **Date of Birth:** |

**New Patient Registration Form (Children: under 16s)**

**Instructions for completing this form on behalf of a Child**

1. Complete a separate form for each child to be registered

2. Complete in BLOCK CAPITALS and tick the boxes and fill in each section as appropriate

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| **2** | **Looking after a family member** | | | |
| **Is your child looking after someone?** Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems | | Yes  No | |
| **Is someone looking after your child?**  Let us know if a family member, friend or neighbour looks after your child due to ill health. | | Yes  No | |
| Carer’s name: | **Relationship to child:** | |  |
| Address of carer : | | |
| Telephone number ofcarer**:** | | |

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| **3** | **Your Child’s Religion**  (Please state) |  | | | | | |
| **Your Child’s Ethnic Origin** (Please State) |  | | | | | |
| **What is your child’s main spoken language?** | | | **Does your child need an Interpreter?**  Yes  No | | | |
| **Does your child need help with mobility/hearing/speaking? (tick all that apply)** | | | | | | |
| Wheelchair | Walking aid | | Hearing aid | | British sign language (BSL) | Makaton sign language |
| Lip reading: | Large print: | | Braille | | Other. ***Please state***: | |
| **Is your child currently?** | Homeless | | A Refugee | | An Asylum Seeker | |
| **Is your child an ‘Assistance Dog’ User?** | | Yes | | No | | |
| **Is your child housebound?** | | Yes  No | | Comments: | | |

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| **4** | **Medical background** | | | | | |
| Are there any serious diseases that affect your child’s **parents, brothers or sisters**?  Tick all that apply ***and*** state **family member**: | | | | | |
| **Diabetes**  Who: | **Asthma**  Who: | **Thyroid disorder**  Who: | | **Stroke**  Who: | **COPD**  Who: |
| **Heart Attack under age of 60**  Who: | **Cancer (Specify type)**  Who: | **High Blood pressure**  Who: | | **Any other important family illness. *Please state*:** | Who: |
| Please state any allergies and sensitivities that your child has to medicines, food & dressings: | |  | | | |
| Please state any mental disabilities your child has: | |  | | | |
| Does your child have any problems taking medicines? | | Yes No | ***If yes*** please give details, e.g. swallowing | | |

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| **4** | **Medical background continued:** | |
| What chronic medical conditions has your child had? | Date of Diagnosis: |
| What operations has your child had? | Date of operation/s: |
| What injuries has your child had? | Date of injury/s |
| Please list any tablets, medicines or other treatments your child is currently taking / undertaking: | |

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| **5** |  | **Which vaccinations has your child had?**  **It is very important that you let us know the dates and types of vaccines that your child has had so that we have an accurate record. If your child has had vaccines abroad and you are unsure for what then please make an appointment with the practice nurse to discuss. Please bring a copy of any vaccines records with the registration form** | | | | | |
| **Age** | **Immunisation** | | **Date Given**  **(DD/MM/YY)** | **Band of Vaccine** | **GP Surgery** | **Private** | **Abroad** |
| **2 months** | 1st Diphtheria, Tetanus, Pertussis | |  |  |  |  |  |
| 1st Polio | |  |  |  |  |  |
| 1st HIB | |  |  |  |  |  |
| 1st Hepatitis B | |  |  |  |  |  |
| 1st Pneumococcal Vaccine | |  |  |  |  |  |
| 1st Rotavirus | |  |  |  |  |  |
| 1st Meningitis B | |  |  |  |  |  |
| **3 months** | 2nd Diphtheria, Tetanus, Pertussis | |  |  |  |  |  |
| 2nd Polio | |  |  |  |  |  |
| 2nd HIB | |  |  |  |  |  |
| 2nd Hepatitis B | |  |  |  |  |  |
| 2nd Rotavirus | |  |  |  |  |  |
| **4 months** | 3rd Diphtheria, Tetanus, Pertussis | |  |  |  |  |  |
| 3rd Polio | |  |  |  |  |  |
| 3rd HIB | |  |  |  |  |  |
| 3rd Hepatitis B | |  |  |  |  |  |
| 2nd Pneumococcal Vaccine | |  |  |  |  |  |
| 2nd Meningitis B | |  |  |  |  |  |
| **12-13 months** | 1st MMR (Measles, Mumps, Rubella) | |  |  |  |  |  |
| 3rd Pneumococcal Vaccine | |  |  |  |  |  |
| Hib/Men C Booster | |  |  |  |  |  |
| 3rd Meningitis B | |  |  |  |  |  |
| **40 month-5 year** | Pre- School Booster Diphtheria, Tetanus,  Pertussis & Polio | |  |  |  |  |  |
| MMR Booster (Measles, Mumps, Rubella) | |  |  |  |  |  |

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| Other vaccine – please state |  |  |  |  |  |
| Other vaccine – please state |  |  |  |  |  |

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| **6** | **Sharing your child’s medical record** |
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| **Medical Record Sharing** allows your child’s complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your child’s shared medical record.  **If you don’t want to share your child’s GP record tick here:** |
| **Summary Care Records** contains details of your child’s key health information – medications, allergies and adverse reactions.  They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your child’s Summary Care Record.  **If you don’t want your child to have a Summary Care Record tick here:** |
| **The Care.data Programme** Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as their GP, hospital and community services, to help them provide a full picture of your child’s medical needs and the care they are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.  **I wish to OPT OUT from my child’s Personal Confidential Data being shared outside their *GP practice*:**  **I wish to OPT OUT from my child’s Personal Confidential Data being shared with *third parties*:** |

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| **7** | **Required Information** | |
| Name of parent/s: | 1.  2. |
| Name of person with legal parental responsibility: |  |
| Name of School or Nursey attended: |  |

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| **8** | **Parent / Guardian permission given** | |
| Permission given for someone other than a Parent/Guardian to accompany your child to an appointment? | |
| Name of person/s:  Relationship: | Parent / Guardian Signature: |

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| **9** | **Signature** | |
| Parent/Guardian signature: | Date: |

**Thank you for completing this form**

***For more information about the services we offer, please refer to our practice leaflet or see our website:***

[*https://belgravia-surgery-sw1.nhs.uk/*](https://belgravia-surgery-sw1.nhs.uk/)