New Patient Registration Form (Child: under 18 years)

Whilst we are waiting for your child's full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that your child's care is transferred as seamlessly as possible.

- **Please complete in BLOCK CAPITALS and tick relevant boxes**
- **Please complete a separate form for each patient to be registered**
- **Please bring in your child's red book so we can take a copy of their immunisation record**
- **When handing in please remember to bring photo ID & proof of address of registering adult**

1	**Your Child's Personal Details.**		
	Title:		
	Full name:	**Date of Birth:**	
		NHS No (if known):	
	Gender: □ Female	□ Male	□ Unspecified
	Current Address:	**Home tel. number:**	
		Mobile tel. number:	
		E-mail address:	

2	**Required Information.**		
	Name of parent(s) / Carer(s)	**Has legal responsibility?**	**Next of kin?**
	1.	**Yes/No**	**Yes/No**
	2.	**Yes/No**	**Yes/No**
	Name of person(s) with legal responsibility if not above:		
	Name of school/nursery attended: **Is child home educated? Yes/No**		
	Please list other family members at your address . Are they registered with us?:		
	Name:	**Relationship to child:**	**Registered with us Y/N**

3	**Your Child's Background Information.** Due to government policy, we are obliged to ask you the following:			
	Your Child's Religion: *(please state)* Please let us know if you feel your religion will affect any treatment you receive			
	Your Child's Ethnic Origin: *(please tick one)*			
	□ Black Caribbean/British	□ White (UK)	□ Indian/British Indian	□ Arabic
	□ Black African/British	□ White (Irish)	□ Pakistani/British Pakistani	□ Chinese
	□ Other Black Background	□ White (Other)	□ Bangladeshi/British Bangladeshi	□ Other: *(please state)*
	□ Other Mixed Background: *(please state)*		□ Other Asian Background	□ I do not wish to state my child's ethnic group
	What is your child's main spoken language?			
	Does your child need an interpreter?		□ Yes	□ No
	Does your child need help with mobility/communication? (please tick all that apply)			
	□ Wheelchair	□ Walking aid Please specify:	□ Hearing aid	□ British sign Language (BSL)	□ Makaton sign language
	□ Lip reading	□ Large print	□ Braille	□ Other:	
	Is your child currently:	□ Homeless	□ A refugee	□ An asylum seeker	
	Is your child currently housebound? If so, please provide details:		□ Yes	□ No
	Is your child a looked after child under the care of the local authority?		□ Yes **If yes, in what capacity?** □ Temporary □ Permanent **Which local authority?** **Name of social worker**.	□ No
	Is your child or family currently involved with Childrens services or have they ever been known to Childrens services or the safeguarding team?		□ Yes **If yes, please give further details** **Name of social worker**	□ No

4	**Looking after a family member/carer.**	
	Is your child looking after someone at home? **If so, who:** Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs, or substance misuse problems.	□ Yes □ No
	If so, do you think they would like additional support as a young carer?	□ Yes □ No
	Is your child known to services such as young carers?	□ Yes □ No
	Is your child being looked after by a friend, neighbour in their home? **Private Fostering** **If yes how long have they been living there?**	□ Yes □ No
	Is someone looking after your child at home? Please let us know if a family member, friend or neighbour helps to look after your child.	□ Yes □ No
	Carer's name and address:	**Relationship to you:** **Carer's Tel. number:**

5	**Your Child's Medical Background.**		
	Please give information about any serious illnesses, operations, or injuries your child has had in the past?		
	Condition	**Year Diagnosed**	**Ongoing Yes / No**
	Is your child registered with a dentist? To find a dentist visit NHS Choices **www.nhs.uk**		□ Yes □ No
	Please provide details of any medication your child takes (including the contraceptive pill):		
	Name:	**Dosage:**	**Frequency:**

Please give details of any allergies or sensitivities your child may have to medication/food:

Please complete the attached Prescription collection nomination form to enable Prescription requests to be sent Electronically to your preferred pharmacy

Family History

Please let us know if any of the following have affected your child's parents/brothers/sisters:

Please list and specify which family member:

□ Heart disease UNDER the age of 60 Who:	□ Thyroid disorder Who:	□ High blood pressure (Hypertension) Who:	□ Learning difficulties Who:	□ Mental Health problems (e.g. Depression) Who:
□ Heart disease OVER the age of 60 Who:	□ Asthma Who:	□ Stroke (CVA) Who:	□ Epilepsy Who:	□ COPD Who:
□ Cancer Who:	□ Diabetes Who:	□ Renal/Kidney Who:	□ Other:	

7 Your Child's Online Access.

You are now able to book appointments and order repeat prescriptions for your child online.

Would you like to register your child for online services?	□ Yes □ No

If yes, please complete and hand in the online registration form in this pack.

8 Parent/Guardian permission given.

Permission given for someone other than a Parent/Guardian to accompany your child to an appointment? E.g. Grandparent, Nanny, childminder

Name of person(s):	**Parent/Guardian Signature:**

9 Your signature.

Parent/Guardian Signature:	**Date:**

Thank you for completing this form

Please see our practice leaflet/website for further information about our team/services.

www.farnhamdene.com

ELECTRONIC PRESCRIPTION SERVICE

"A new way to get your medicines and appliances"

Farnham Dene Medical Practice would like to encourage all our patients to sign up to this Electronic Prescription service as it is provides a number of benefits to prescribers, dispensers and not least of all to you the patient. It is safe and reliable. For more information you can ask at your local pharmacy or visit: http://systems.hscic.gov.uk/eps

What does this mean for you?
You can collect repeat prescriptions directly from a pharmacy without visiting your GP and you won't have a paper prescription to loose.

How to use EPS?
It's simple – just fill in the details below and we'll do the rest when we register you

Can I change my pharmacy and get a paper prescription?
Yes, you can do this at any time. You can also change your nomination by telling us your GP or registering with a new pharmacy.

Name and address of nominated dispenser:

Signed:	**Print name:**
_____	_____
D.O.B _____	**Date:** _____

The Farnham Dene MEDICAL PRACTICE

PROXY ACCESS

Proxy Access allows parents, family members, and carers to have access to their patient's online service account to book appointments, request repeat medication and where applicable, view their medical record.

If you would like to become a proxy user please print your details clearly below.

Your name:				
Your date of birth:				
Your email address:				
Do you already have an online account?	**Y/N** If you do not already have an online account you will be required to complete the GP Online Services Registration form.			
Patient Name (child, person being cared for)	Date of Birth	Relationship to you	Access to medical records required	Patient permission signature (required for patients aged 11 and over)
			Y/N	
			Y/N	
			Y/N	
			Y/N	
I AM AWARE THAT I AM RESPONSIBLE FOR THE SECURITY OF THE INFORMATION I SEE OR DOWNLOAD	Signature			
I **WILL CONTACT THE PRACTICE AS SOON AS POSSIBLE IF I SUSPECT MY ACCOUNT HAS BEEN ACCESSED BY SOMEONE WITHOUT MY AGREEMENT**	Signature			

Please note that Proxy Access is only available for users of Patient Access. Also Proxy Access will be automatically switched off when the patient turns 16, and either full access or proxy access will need to be re-applied for by completion of an online services registration form.

Summary Care Records

Your emergency care summary

NHS Surrey

The Farnham Dene Medical Practice has joined the national Summary Care Record programme which enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS Spine. This summary record could be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline.
Please indicate below whether you would like to have your own Summary Care record by indicating your decision below. A full explanation of each choice follows.

	My decision	**Tick ONE**
1.	I wish to have a Summary Care record containing my medications, allergies and adverse reactions or sensitivities to medications	
2.	I do not wish to have a Summary Care record	

1. A Summary Care record will be created for you from your details held on our GP clinical system and will contain:

   a. any record we have of your current repeat medication, any acute medication (one-offs e.g. antibiotics) and any recently discontinued medication
   b. any record we have of adverse reactions to medication
   c. any record we have of your allergies

2. A note will be made in your records that you do not wish to have a Summary Care Record. Please note that if you attend A&E or if you need emergency treatment when the GP Practice is closed the clinicians treating you may not have access to key information to help them give you the most appropriate treatment.

Surname		Signature
First names		
Date of birth		

Hand this form to reception.

For further information contact the Summary Care Record Information Line:
0300 123 3020-

If you would like this letter or any other information in an alternative format, for example large print or easy to read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know.