WATERCRESS MEDICAL

New Patient Registration Form

(for all new patients under 16)

Please bring the child's Red Book when registering so a copy of their immunisations can be taken

Complete in **BLOCK CAPITALS** and tick the boxes as appropriate

Complete a separate form for each family member (under 16) to be registered

Child's Personal Details:

Please complete all pages in FULL using BLOCK capitals

Child's Surname:

Child's First Names (in full):

Previous Surnames:

Title: ❒ Master ❒ Miss ❒ Ms ❒ Male ❒ Female

Date of Birth (day/month/year): | | | | | | | | NHS Number: (if known) | | | | | | | | | | |

Town & Country of Birth:

Address:

Post Code:

Home Telephone Number: | Mobile Number[1]:

[1] Note, we use the mobile number for text messages. Text messages will automatically cease when the Child is 11 years old.

Email Address[2]:

[2] Please specify whose above email address this is, e.g. parent, carer etc.

Name of Parent(s) / Carers	Has Parental Responsibility?		Next of Kin?	
1.	❒ Yes	❒ No	❒ Yes	❒ No
2.	❒ Yes	❒ No	❒ Yes	❒ No
If not the above, name and contact details of person with legal responsibility:				

Does the child have any special communication / mobility needs? ❒ Yes ❒ No

If yes: ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print

❒ Lip Reading ❒ Braille ❒ British Sign Language

❒ Makaton Sign Language ❒ Other: ……..

Is the child currently: ❒ A Refugee ❒ An Asylum Seeker

Is the child a 'Child in Care'? ❒ Yes ❒ No

Is the child a 'Looked After Child'? ❒ Yes ❒ No

If yes to either of the above questions, in what capacity? ❒ Temporary ❒ Permanent

Is the child home educated? ❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Name of child's nursery/school ……

Has the child or family either currently or in the past been known to Children's Services?

❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Required Information:

Is your child looking after someone at home? ❒ Yes ❒ No

If so, who[3]?

[3] Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult's relationship to the child?

Do you think the child would like additional support as a Young Carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

If yes, please provide carer's name:

Carer's relationship to child:

Contact details of carer:

Are Children's services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (**S.66 Children Act 1989**) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the **Children Act 1989, section 105**:*'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.*

Please help us trace the child's previous medical records by providing the following information:

Your previous address in the UK:	Post Code:
Name of previous Doctor while at that address:	
Surgery Name and Address of previous Doctor:	Post Code:

If you are from abroad:

Your first UK address where Registered with a GP:	Post Code:
If previously resident in UK date of leaving:	Date you first came to the UK:

If registering a child under 5:

❒ I wish the child above to be registered with Watercress Medical for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*:

For Dispensing Practices only:

❒ I live more than 1 mile in a straight line from the nearest pharmacy

Child's Personal Medical History:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No
		Yes/No

Family Medical History:

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

Child's List of Current Medication:

Name of Medication	Dosage

Child's Allergies:

Please list any allergies the child has to any drugs/medications or if known egg or peanut allergy:

Name of Medication	What was the problem or upset?

Child's Ethnicity:

❒ British or mixed British ❒ Irish ❒ African ❒ Caribbean ❒ Indian ❒ Pakistani
❒ Bangladeshi ❒ Chinese ❒ Other (please state):
❒ Decline to state

Child's Religion:

Please state religion of child:

Please advise if you feel your child's religion will affect any treatment received: ❒ Yes ❒ No

Child's Language:

Please state child's main spoken language:

Does the child need an interpreter? ❒ Yes ❒ No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read Appendix A which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for Watercress Medical to contact you by the following:

By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

Signatures:

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ❒ Signature of patient ❒

Name of Person Relationship to Child:

Box for extra details:

APPENDIX A - Data Sharing

Please complete the information below with your choices on sharing your data and hand to Reception.

Name:…… Date of Birth:……

Address:……

……

National Data: Your data may sometimes be used for research and planning to improve healthcare services. For more information, or if you do not wish for your data to be used in this way, please visit www.nhs.uk/your-nhs-data-matters/ **The Practice is no longer able to opt out for you.**

Summary Care Record:

I do not wish to have a Summary Care Record ☐

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication)

Care & Health Information Exchange (formerly Hampshire Healthcare record):

I do not wish to have a Care & Health Information Exchange Record ☐

Secondary Uses:

I would like to opt-out of **all** 'secondary' uses of my GP Record ☐

EMIS Web:

I would like to opt-out of EMIS Web data streaming, please disable this from my GP Record ☐

Signed:…… Date:……