The Bartlett Group Practice

New Patient Registration Form (Child: under 16 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**

<table>
<tr><td>3</td><td colspan="5"><u>Your Child’s Background Information.</u> Due to government policy, we are obliged to ask you the following:</td></tr>
<tr><td></td><td colspan="5">Your Child’s Religion: (please state)
Please let us know if you feel your religion will affect any treatment you receive</td></tr>
<tr><td></td><td colspan="5">Your Child’s Ethnic Origin: (please tick one)</td></tr>
<tr><td></td><td>☐ Black Caribbean/British</td><td>☐ White (UK)</td><td>☐ Indian/British Indian</td><td colspan="2">☐ Arabic</td></tr>
<tr><td></td><td>☐ Black African/British</td><td>☐ White (Irish)</td><td>☐ Pakistani/British Pakistani</td><td colspan="2">☐ Chinese</td></tr>
<tr><td></td><td>☐ Other Black Background</td><td>☐ White (Other)</td><td>☐ Bangladeshi/British Bangladeshi</td><td colspan="2">☐ Other: (please state)</td></tr>
<tr><td></td><td colspan="2">☐ Other Mixed Background: (please state)</td><td>☐ Other Asian Background</td><td colspan="2">☐ I do not wish to state my child’s ethnic group</td></tr>
<tr><td></td><td colspan="5">What is your child’s main spoken language?</td></tr>
<tr><td></td><td colspan="2">Does your child need an interpreter?</td><td>☐ Yes</td><td colspan="2">☐ No</td></tr>
<tr><td></td><td colspan="5">Does your child need help with mobility/communication? (please tick all that apply)</td></tr>
<tr><td></td><td>☐ Wheelchair</td><td>☐ Walking aid
Please specify:</td><td>☐ Hearing aid</td><td>☐ British sign Language (BSL)</td><td>☐ Makaton sign language</td></tr>
<tr><td></td><td>☐ Lip reading</td><td>☐ Large print</td><td>☐ Braille</td><td colspan="2">☐ Other:</td></tr>
<tr><td></td><td colspan="2">Is your child currently: ☐ Homeless</td><td>☐ A refugee</td><td colspan="2">☐ An asylum seeker</td></tr>
<tr><td></td><td colspan="2">Is your child currently housebound?
If so, please provide details:</td><td>☐ Yes</td><td colspan="2">☐ No</td></tr>
<tr><td></td><td colspan="2">Is your child a looked after child under the care of the local authority?</td><td>☐ Yes
If yes, in what capacity?
☐ Temporary
☐ Permanent
Which local authority?
Name of social worker.</td><td colspan="2">☐ No</td></tr>
<tr><td></td><td colspan="2">Is your child or family currently involved with Childrens services or have they ever been known to Childrens services or the safeguarding team?</td><td>☐ Yes
If yes, please give further details
Name of social worker</td><td colspan="2">☐ No</td></tr>
</table>

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:

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.bartlettgrouppractice.co.uk

Summary Care Record:	
This practice has started 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. 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.(9Ndm)		
2. I wish to have a Summary Care record with the above plus additional important medical information held on my record. (9Ndn)		
3. I do not wish to have a Summary Care record. (9Ndo)		

1. A Summary Care record will be created for you from the 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 Summary Care record will be created for you containing the details itemised above in 1. PLUS important additional information you and your GP agree would be useful (e.g. Diagnoses – Asthma, Diabetes etc; Pacemaker, End of life care etc) Please discuss this with your GP practice at your next visit.
3. 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.

For further information contact the Summary Care record Information Line: 0300 123 3020 or visit the Health and Social Care Information Centre website:http://systems.hscic.gov.uk/scr

Signed	**Date**

If you are filling this form on behalf of another person, please ensure that you fill out their details above, sign and provide your details below:

Name:	**Parent**	**Legal Guardian**	**Lasting power of attorney for health and welfare**

For internal use only						
Registration Forms checked						
Mandatory signature checked	GMS1		Zero Tolerance		SCR	
Address validation	Type		Official No.			
ID checked	Type		Official No.			