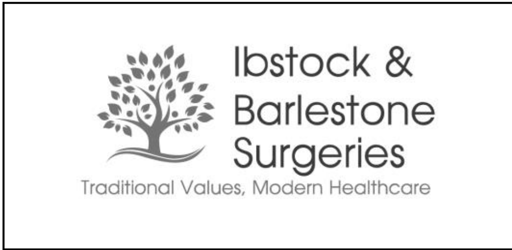
New Patient Registration Questionnaire (Children 0-16 years)



Ibstock & Barlestone Surgeries
132 High Street
Ibstock
Leicestershire
LE67 6JP
Email: ibstockhouse@nhs.net
Website: www.ibstockhousesurgery.nhs.uk

Thank you for applying to join Ibstock & Barlestone Surgeries. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.
Fields marked with an asterix (*) are mandatory

*Title: *Surname:	*First names:
*Any previous surname(s) (if applicable):	*Date of Birth:
* ☐ Male ☐ Female	*NHS No. ☐☐☐ ☐☐☐ ☐☐☐☐
*Town and country of birth:	*Home address & Postcode:
*Home telephone No.:	*Previous address & Postcode:
Work telephone No.:	
*Mobile No. (if you have one):	Email address:

Communication Preferences

*Do you consent to receive the following types of communication from Ibstock & Barlestone Surgeries?

Email ☐ Yes ☐ No

Mobile phone text messages ☐ Yes ☐ No

Answering machine messages ☐ Yes ☐ No

What is your preferred method of contact? Please circle one: SMS / Email / Letter

Additional details about you

Main spoken language (E.g. English): .... **Do you require the help of a translator/Interpreter?** Yes / No

What is your ethnic group?

White	☐ British	☐ Irish	☐ Other White (please specify):		
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):		
Asian	☐ Indian	☐ Pakistani	☐ Chinese	☐ Other Asian (please specify):	
Mixed	☐ White + Black Caribbean		☐ White + African	☐ White + Asian	☐ Other mixed

Next Of Kin

1
Name: ………………………………………………… Relationship to you: …………………………………………………
Telephone No. ………………………………………………… Address (if different to yours) ……………………………………………………………………

2
Name: ………………………………………………… Relationship to you: …………………………………………………
Telephone No. ………………………………………………… Address (if different to yours) ……………………………………………………………………

If you are applying on behalf of a child who is in foster/residential/Kinship Care or who is not your child

Who has legal responsibility for the child?

☐ You as the legal parent or guardian (Name: …………………………………………………)

☐ Other Please specify: ………………………………

Who can consent for the medical treatment for the child?

☐ You as the legal parent or guardian (Name: …………………………………………………)

☐ Other Please specify: ………………………………

Does the child have a named Social Worker? ☐Yes ☐No

If yes please provide the following information:

Name: …………………………………………………… Contact details: ……………………………………………………

Looked after Children

Are you (child) a looked after child? ☐ Yes ☐ No

If Yes, under what arrangements:
☐ Section 20-Voluntary Care ☐ Interim Care Order ☐ Care Order ☐ Child arrangement order/Residence Order
☐ Special Guardianship order ☐ Placed for adoption ☐ Private arrangement/Private Fostering/informal arrangement

(Please note you have a duty to notify social care of this arrangement)

A **child** who is being **looked after** by their local authority is known as a **child in care**. They might be living: with foster parents, at home with their parents under the supervision of social services or in **residential children's homes**.

Carers Information

A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

Does the child have a Carer? ☐Yes ☐No

If yes, what is their name and contact number?

Does the child consent for the carer to be informed about their medical care (if applicable)? ☐Yes ☐No

Is the child a Carer? ☐Yes ☐No

If yes, what is their name: ………………………………………………… Are they a ☐Friend ☐Relative ☐Neighbour

Information and Communication Needs

*Does the child have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support their needs:

The Accessible Information Standard (AIS)
Please use this space to tell us about any specific communication needs the child has. I.e. needing information in large print or deafblind telephone contact. For further information please visit **https://www.england.nhs.uk/ourwork/accessibleinfo/**

Electronic Prescription Service (EPS)

EPS enables prescribers, such as GP's and Practice Nurses, to send prescriptions electronically to a Pharmacy of your choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
EPS may be particularly useful to patients who:
- Have a repeat prescription but don't want to collect it from the Practice every time.
- Have a regular pharmacy you collect from which may be closer to your home or workplace.

Please let us know your chosen nominated pharmacy if you wish to take advantage of this service:……………………………………………………….

Medical details

*Is the child currently taking any prescribed medications? ☐ Yes ☐ No (if yes please specify)

If yes, please ensure you have 1 months' supply of medication from your current GP Practice before registering.

*Is the child allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies / intolerances (i.e. pollen, animal hair or certain foods. Please mark "none" if the child has no other allergies that you know of) :

Has the child ever had any of the following conditions?

Condition		
Epilepsy	☐ Yes	Year
High Blood Pressure	☐ Yes	Year
Heart Attack / Angina	☐ Yes	Year
Stroke / Mini-Stroke (TIA)	☐ Yes	Year
Cancer	☐ Yes	Year
Rheumatoid Arthritis	☐ Yes	Year

Condition		
Mental Illness (inc Depression)	☐ Yes	Year
Diabetes (type 1 or type 2)	☐ Yes	Year
Asthma	☐ Yes	Year
COPD (or Emphysema)	☐ Yes	Year
Osteoporosis / Bone Fractures	☐ Yes	Year
Peripheral Vascular Disease	☐ Yes	Year

Height ______ Feet ______ Inches Waist measurement ______ Inches

Weight ______ Stone ______ Pounds

Does the child have Family History of any of the following?

Condition		
High Blood Pressure	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who
Stroke / CVA	☐ Yes	Who
Asthma	☐ Yes	Who

Condition		
DVT / Pulmonary Embolism	☐ Yes	Who
Breast Cancer	☐ Yes	Who
Any Cancer Specify type:	☐ Yes	Who
Thyroid disorder	☐ Yes	Who
Epilepsy	☐ Yes	Who
Osteoporosis	☐ Yes	Who

Data Sharing

Electronic Data Sharing Module (EDSM)

Healthcare places can usually share information from your records by letter, email, or phone but this can slow down your treatment or mean information is hard to access. However you can choose to share your record electronically between care services. **For more information please visit our website at** *www.ibstockhousesurgery.nhs.uk*

Tick this box if you wish to opt-in to the EDSM ☐

Tick this box if you wish to opt-out to the EDSM ☐

Summary Care Record (SCR)

The Summary Care Record is a 'short summary' of your GP medical record which includes:

- medications;
- allergies;
- adverse reactions.

As well as at your GP Practice, the Summary Care Record can be used by other NHS organisations such as A&E, Out of Hours / NHS 111 and Pharmacies.
Due to these organisations not having access to your full GP medical record, being able to view your SCR may enable them to treat you more efficiently.

Other NHS organisations will ask for your consent before viewing your SCR. In an emergency, if you are unable to provide consent, for example if you were unconscious, your SCR can still be viewed but only by health and care staff with the right levels of security clearance, so your information is secure.

You can also consent to including 'additional information' into your SCR which includes:

- diagnoses;
- current problems and issues;
- vaccinations;
- consent and personal preferences;
- details of your care professionals / carers;
- care plan events;
- social and personal circumstances.

If you do not have a Summary Care Records NHS health and care staff caring for you may not be aware of your medications, allergies and adverse reactions in order to treat you safely.

More information can be found by visiting www.nhscarerecords.nhs.uk

Tick this box if you wish to opt-in to the Core SCR ☐

Tick this box if you wish to opt-in to the Core an Additional SCR ☐

Tick this box if you wish to opt-out of the SCR ☐

Your Name Accountable GP

Under the terms of the latest GP Contract, all patients must have a Named Accountable GP.
Having a Named Accountable GP does not prevent you from seeing any other GP in the Practice. If your Named Accountable GP is unavailable abd you require urgent medical attention you may need to discuss this with another GP. Please note that your medical records are availbale to all the GPs in the practice.
Should you wish to change your Named Accountable GP; the Practice will make reasonable efforts to accommodate this request.

Your Named Accountable GP is:

Dr S Johri   Dr C Luke   Dr F Houghton   Dr R Sil

Community Health Services

At Ibstock & Barlestone Surgeries we have an agreement with Community Health Services that incorporates a Children's Health Visiting and School Nursing Liaison service, whereby a Health Visitor is allocated and based at the Practice.

The Health Visitor's contact details are below:
Base: Ibstock Surgery
Telephone number: 01530 264 928

The School Nursing Services' details are below:
Base: Ashby Hospital
Telephone number: 01530 566911

Your Health Visitor is: **Helen Stamp**

Please record any additional information about you that you think is important for us to know on a separate sheet of paper and attached to this questionnaire form.

***Signed on behalf of patient**

Print name: ___________________________________

Relationship to patient: ________________________

***Date** / / /

Please also complete the Health Visitor Registration form attached to the back of this questionnaire

New Child Registration Form
Health Visitor

Patient:

*Title:	*First names:	*Surname:
*Any previous surname(s) (if applicable):	*Date of Birth:	
*☐Male ☐Female	*NHS No. ☐☐☐ ☐☐☐ ☐☐☐☐	
*Town and country of birth:	*Home address & Postcode:	
*Home telephone No.:	*Previous address & Postcode:	
Work telephone No.:	*Mobile No. (if you have one):	
Email address:		

Parent/Guardian:

*First name(s):	*Surname:
*Any previous surname(s) (if applicable):	*Date of Birth:
*☐Male ☐Female	*NHS No. ☐☐☐ ☐☐☐ ☐☐☐☐
*Town and country of birth:	*Home address & Postcode:
*Home telephone No.:	*Previous address & Postcode:
Work telephone No.:	*Mobile No. (if you have one):
Email address:	

Parent/Guardian:

*First name(s):	*Surname:
*Any previous surname(s) (if applicable):	*Date of Birth:
*☐Male ☐Female	*NHS No. ☐☐☐ ☐☐☐ ☐☐☐☐
*Town and country of birth:	*Home address & Postcode:
*Home telephone No.:	*Previous address & Postcode:
Work telephone No.:	*Mobile No. (if you have one):
Email address:	

PTO

GP Practice Details:

GP Practice: Ibstock & Barlestone Surgeries 132 High Street Ibstock Leicestershire LE67 6JP Tel: 01530 263 467	**Named Accountable GP:** Dr S Barrett
Previous GP Practice: **Name:** **Address:** **Tel:**	**Previous Health Visitor:**

Signature: **Print name:**	**Date:** **Relationship to patient:**

Thank you for completing this registration form.

By signing this form you are agreeing for the child's information to be shared with the Health Visitor and School Nursing Services (if of school age)