CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female ☐

Date of Birth (day/month/year)

NHS Number (if known)

Town & country of Birth

Address

Post Code:

Telephone number:

Mobile number:

Email address:

Please help us trace your previous medical records by providing the following information:

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

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 UK

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Smoking Status…..

Over 15's only.

Do you smoke? **Yes/No**

If NO have you ever smoked, when did you stop?..

If YES how many do you smoke a day? ……………………………………………………………

Family History…..

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

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible pelase 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			

List of current medication ……

Name of medication	Dosage

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

Ethnicity ……

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

Next of kin ……

Name:

Tel. contact number:

Relationship:

Data sharing consent choices ……

Summary Care Record

There is a new Central NHS Computer System called the Summary Care Record (SCR). It is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had to support your emergency care. Only healthcare staff involved in your care can see your Summary Care Record.

Please sign here if you are happy for data to be shared: Signature……………………………………..

You are allowed to opt out - Opt out forms can be found on our website www.stoursurgery.co.uk or please ask at reception.

Additional Information for your Summary Care Record(SCR)

You can also choose to include more information in your SCR such as significant medical history, immunisations, patient preferences and particular care needs. Please ask at reception for an information leaflet.

Please sign here if you are happy for additional information to be added to your SCR:
Signature……………………………………..

Shared Data

On occasion, information may need to be shared with other staff or organisations in order to help them decide the best care and treatment available.

Other organisations may include District Nurses, Health Visitors etc. or other service providers commissioned and appointed by the CCG that are committed to the improvement of health outcomes for patients.

When members of staff from different organisations are involved they will only be allowed access to information that is relevant to the purpose of their job/role and will not necessarily have access to your medical history.

If you would like to OPT OUT of shared data please sign here: Signature………………………………

Contacting You…….

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

By email	☐ Yes	☐ No	This will be to send you letters, newsletter and the like
By text	☐ Yes	☐ No	This will be to send you reminders of appointments via text

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.
For more *information please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0300 123 23 23*

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

…………………………………………………………………………………………… Post code: ……………………

Named Accountable GP

All patients at this practice will be allocated a named GP who is responsible for your overall care. Our reception staff will advise you at time of registration, however if you have a preference as to who this is we will make reasonable efforts to accommodate your request.

Accessible Information

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know. We want to know if you need information in braille, large print or easy read.

Signature ……

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 ☐