Bishops Waltham Surgery
Phone: 01489 892288 / Email: whccg.bwsurgery@nhs.net

New Patient Registration (CHILDREN UNDER 16)

About You

Surname: …… Forename(s): ……

Date of Birth (dd/mm/yyyy): ……

Gender: ……

Contact Information

Address: ……

Telephone: …… Mobile: ……

Email: ……

Please circle below your preferred choice of contact:

Text Phone (mobile) **Phone (home)** **Email** **Post**

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

I AM under 18 and my parent(s) are serving member(s) of the armed forces	☐	**I AM** under 18 and my parent(s) are veteran(s) of the armed forces	☐

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

Country of Birth

In which country were you born? ……

Main Language

Which is your main language? ……

Do you need an interpreter? ……

☐ ☐
☐ ☐
☐ ☐
☐ ☐

Parent / Guardian / Foster Parent Details

Name: …… Telephone Number: ……

Relationship to Child: ……

Name: …… Telephone Number: ……

Relationship to Child: ……

Next of Kin

Surname: …… Forename(s): ……

Gender: ……

Emergency contact information (for next of kin)

Telephone: …… Mobile: ……

Contacting You

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit to your medical care

Do you consent to the Surgery sending letters to your home address? **Yes** **No**

Do you consent to the Surgery sending text messages to your mobile? **Yes** **No**

Do you consent to the Surgery sending messages to you by email? **Yes** **No**

Do you consent to the Surgery leaving messages on your phone? **Yes** **No**

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Do you have a preferred method of contact? ……

Summary Care Record (SCR)

If you decide to have a SCR, it will contact important information about any medicines you are taking, allergies you suffer from, and any bad reactions to medicines that you have had, it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

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).

I wish to opt out of SCR ☐

Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patients' choice. The makes the prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy: ……

Address: ……

Dispensing Patients only

☐ I live more than 1 mile (1.6km) "as the crow flies", from the nearest chemist / pharmacy and would therefore like the surgery to dispense my medicines and appliances

☐ I am housebound/disabled/elderly and cannot get to a pharmacy easily and would like to register for the home delivery service

If you are unable to be a dispensing patient please nominate a pharmacy for your prescriptions to be sent to.

Required Information

Is the child currently:	A Refugee ☐	An Asylum Seeker ☐
Is this 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 ☐
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:		

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

If so, who?

……

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 carer's?
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:	

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'.*

Personal Medical History

Type of Birth:
(if under 5)
(e.g. normal, forceps, Caesarean)

Birth Weight:
(if under 5)

Feeding:
(if under 5)
(Breast or Bottled)

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

Are you dependent on a wheelchair? **Yes** ☐ **No** ☐

Do you have any problems with your speech? **Yes** ☐ **No** ☐

Do you have any other disabilities? If so please record the nature of the disability: …….

Family History

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Condition	Yes	No
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		
Hypertension		
Rheumatoid Arthritis		
Epilepsy		
Glaucoma		
Parkinson's Disease		

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.

Immunisation	Year	Immunisation	Year	Immunisation
1st Infanrix Hexa DTP, IPV HIB, HEPB		1st Pneumonia (Prevenar)		
2nd		2nd Pneumonia		
3rd		Menintorix (HIB/MEN C)		
1st Rotarix		1st MMR		
2nd		2nd MMR		
1st Meningitis B		DTP + IPV (Preschool)		
2nd		DTP (Aged 14)		
3rd		1st HPV		
		2nd		
		Men ACWY		

Under 5s – Please provide copy of immunisation record

Allergies

Please list any allergies your child has to any Drugs / Medication:

Name of Medication	What was the Problem or Upset?

Current Medication

If you have a copy of your child's repeat medications, please pass to Reception to copy

Name of Medication	Strength	Dosage

Household Members

Are there any other children in the household? ……

Which school does your child attend? ……

Does your Child have any special educational needs? ☐ **Yes** ☐ **No**

Details:

Signature

I confirm that the information I have provided is true to the best of my knowledge:

Signature: ……

Date: ……