

Dr R Kapur & Partner Only

Children Registration Form – Under 16

****For children up to 16 years of age****

Thank you for applying to join Dr R Kapur & Partner. We would like to gather some information about your child 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 the best possible care. **Please supply the child's birth certificate or a form of Identification with the completed form, a photographic form of ID (such as passport) and proof of your home address (such as a recent bank statement or document relating to your new home).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.

Fields marked with an asterisk (*) are mandatory.

*Title	*Surname	*First names	
*Any previous surname(s)		*Date of Birth	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified		*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Town and country of birth		*Home address & Postcode	
Home telephone No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No		*Previous address & Postcode	
Parent / Carer's No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No		Email address	
Mobile No. Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/>			

Parental Responsibility / Delegated Responsibility Mothers Name: - Fathers Name: - Other: -
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*Previous GP Details: *School that child is registered with:

*Is the child a looked after child? <input type="checkbox"/> Yes <input type="checkbox"/> No 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.

If you are from abroad

*Your first UK address where you registered with a GP

Postcode

*If previously a resident in the UK, date of leaving

*Date you first came to live in the UK if applicable

***I would describe the child's ethnic group as (please tick)**

White	<input type="checkbox"/>	British	<input type="checkbox"/>	Irish		
Black	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	African		
Asian	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Chinese
Mixed	<input type="checkbox"/>	White + Black Caribbean	<input type="checkbox"/>	White + African	<input type="checkbox"/>	White + Asian
Other	<input type="checkbox"/>	Please specify:				

Is the child a dependant of a current serving member of British Armed Forces? Yes No

Child's Main Language Spoken? (E.g. English)

Next of kin \ Emergency contact.

Is the contact named below authorised to discuss the child's medical record with us? Yes No

Name of next of kin \ Emergency contact

Relationship to you

Next of kin \ Emergency contact telephone number(s)

Next of kin \ Emergency contact address (if different to above)

Safeguarding

Are you aware of any Safeguarding concerns?
Please give details below:

Data Sharing

Summary Care Record (SCR)
The SCR is an electronic record summary held on the central NHS database. It provides authorised care professionals with faster, secure access to essential information about you when you need care i.e. medications you are currently receiving.
More information can be found by visiting: <http://systems.digital.nhs.uk/scr>.
Tick this box if wish to opt-out of the SCR

Medical Interoperability Gateway (MIG)
The MIG enables secure sharing of relevant medical information from your GP record with other healthcare professionals who are providing you with direct care, even if they are not using the same electronic records system. At point of care, you will be asked if you consent to the care service seeing essential elements of your record.
More information can be found by visiting: <http://www.healthcaregateway.co.uk/products>.
Tick this box if you wish to opt-out of the MIG data sharing

Enhanced Data Sharing Module (EDSM)

Dr Kapur and Partner use a clinical computer system called SystmOne to record your medical information. With your consent, you can allow your full GP record to be shared with other healthcare services that are providing care for you and who also use SystmOne. These other services will always ask consent to view your record. **For more information, please visit our website at <https://www.narboroughroadsurgery.co.uk>**

Tick this box if you wish to **opt-out** of the Enhanced Data Sharing Module

*Do you consent to receive the following types of communication (if offered) from Dr R Kapur & Partner Surgery

Email Yes No

Mobile phone text messages Yes No

Answering machine messages Yes No

Carers Information

A carer is a friend or 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.

Is the child looked after or supported by someone who they couldn't manage without? Yes No

If yes, what is their name and contact number?

Do you consent for the carer to be informed about the child's medical care? Yes No

Does the child look after or support someone who couldn't manage without them? Yes No

If yes, do they look after someone who is a patient of Dr R Kapur & Partner Surgery? Yes No Don't know

If yes, what is their name?

Are they a: Relative Friend Neighbour

Please detail any contact that the child has with other professionals such as health visitors and social workers.

Medical details

In order to continue to receive repeat medications you'll need to make a new patient health check appointment for the child and bring in their last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats. Please provide us with you repeat medication list found on the right-hand side or a printed prescription.

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

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

Teaching & Training Practice

Our practice is a teaching and training practice. You may be seen by a Medical Student or a GP Registrar or there maybe students present during your consultations with the clinicians. Please let the reception know when you come in for your appointment if you do not wish to have the presence of students during your consultation.

Please tick if you would like to have a medical student present Yes No

Child Immunisation – please complete if not registered before in UK.

<u>AGE DUE</u>	<u>IMMUNISATION</u>	<u>DATE GIVEN</u>	<u>Which Country Given</u>
BCG (At Birth)			
2 Months	DTaP/IPV/Hib + PCV		
	Hep B		
3 Months	DTaP/IPV/Hib + Mec C		
	Hep B		
4 Months	DTaP/IPV/Hib + PCV		
	Hep B		
9 months	MMR		
12 Months	Hib/Mec C + PCV		
12 Months	MMR		
3½ - 5 Years	DTaP/IPV (PSB)		
3½ - 5 Years	MMR		
12-13 Years (Girls Only)	HPV		
13 To 18 Years	Td/IPV (Revaxis) + Men ACWY		
	Other:		

Has the child ever had any of the following conditions?

Epilepsy	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack / Angina	<input type="checkbox"/> Yes	Year
Stroke / Mini-stroke (TIA)	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year
Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year

Mental Illness	<input type="checkbox"/> Yes	Year
Diabetes	<input type="checkbox"/> Yes	Year
Asthma	<input type="checkbox"/> Yes	Year
COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Osteoporosis / Bone fractures	<input type="checkbox"/> Yes	Year
Peripheral vascular disease	<input type="checkbox"/> Yes	Year

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 your child may have. I.e. needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

Please see attached form

Does the child have family history of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who

DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Breast Cancer	<input type="checkbox"/> Yes	Who
Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Thyroid disorder	<input type="checkbox"/> Yes	Who
Epilepsy	<input type="checkbox"/> Yes	Who
Osteoporosis	<input type="checkbox"/> Yes	Who

Please tell us about the child's smoking habits

Does the child smoke? Yes No

If Yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe (please circle)

How many does the child smoke a day?
Would you like advice on quitting? Yes No

Is the child an ex-smoker Yes No
When did they quit?

How many did you used to smoke a day?

Does your child exercise regularly? Yes No

If so – What exercise do they take?

How often?

*In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3rd party to collect prescriptions, test results and other medical information on your child's behalf. Please complete this section if you would like to register a 3rd party.

I give consent for _____ to collect prescriptions on my child's behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for _____ to obtain test results / medical information / appointment information on my child's behalf (Delete as appropriate). **You will also need to complete a Patient consent form at the Practice when you hand in your documents.**

IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:

Signed: _____

Date: _____

Please record any additional information about your child that you think is important for us to know

Electronic Prescription Service (EPS)

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service, please talk to your pharmacist of choice.

As from 2.3.2020 the Dr R Kapur & Partner Surgery now uses prescription tokens . Patients without a nominated pharmacy will be given a "prescription token"; the token will have a longer barcode down the right-hand side of the prescription and a doctor's signature is no longer required. This will be given to the patient (or their representative) or collected as part of a prescription collection service. Patients can take these tokens to any pharmacy in England.

For the 30+ million patients who already have a nominated pharmacy the nomination will remain valid, and nothing will change. Patients with a nominated pharmacy do not need to collect tokens.

NHS Organ Donor registration in England has changed

What has changed?

Organ donation in England has moved to an 'opt out' system. You may also hear it referred to as '**Max and Keira's Law**'. This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the **excluded groups**. Parents and Guardians can register their children and children can register themselves.

Your family will still be approached, and your faith, beliefs and culture will continue to be respected.

You still have a choice whether or not you wish to become a donor. **Get the facts** about organ donation to help you decide.

Please see the attached information

**For more information, please visit the website www.organdonation.nhs.uk or call 0300 303 2094
Minicom 0845 730 0106, Text Chat 07860 034343**

For more information, please visit the website www.uktransplant.org.uk or call 0300 123 23 23

***Signed**

***Date** / / /

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

Once you are registered...

If there are any problems with your child's registration, we will contact you to clarify any issues, but once your details have been entered into our computerized records...

On-line Services

...It may be possible for the child or parent/carer to access particular patient record services online. Please ask reception if you would like more details.

FOR OFFICE USE ONLY

Birth Certificate
Seen.

ADDRESS ID
(if applicable)