New Patient Registration Form
Child 14-17

Please complete all pages in full using block capitals

1. Background Details

Your Child Details			
Child Name			
NHS Number		Gender	
Address		Date of Birth	
		Home Telephone	

Parent or Guardian Details 1			
Your Name		Relationship	
Address		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Family Registered With Us			

Parent or Guardian Details 2			
Your Name		Relationship	
Address		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Family Registered With Us			

***It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.**
We may contact you with appointment details, test results, health campaigns or Patient Participation Group details
If you do NOT consent to being contacted by SMS or Email, please tick here:
☐ **SMS** ☐ **Email**

Communication Needs	
Language	What is your main spoken language? Do you need and interpreter? ☐ Yes ☐ No
Communication	Do you have any communication difficulties? ☐ Yes ☐ No If **Yes** please identify below ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog

2. Medical History

Medical History

Does your child suffer from any of the following conditions?

☐ Asthma ☐ Depression ☐ Diabetes ☐ Epilepsy

Any other conditions, operations or hospital admission details:

If your child is currently under the care of a Hospital or Consultant outside our area, please tell us here:

Family History

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma…… ☐ Heart Disease…… ☐ Diabetes ……. ☐ Depression……..
☐ COPD……. ☐ Stroke ……. ☐ Kidney Disease ……. ☐ Thyroid……
☐ Epilepsy…….. ☐ Blood Pressure….. ☐ Liver Disease ……. ☐ Cancer……

Other:

Allergies

Please record any allergies or sensitivities below:

Current Medication

Please check and include as much information about your child's current medication below
If they have a previous repeat medication list please give this to us & they may need a medication review appointment.

3. Your Lifestyle

Alcohol

Please answer the following questions which are validated as screening tools for alcohol use:

AUDIT–C QUESTIONS	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL:	

A score of **less than 5** indicates *lower risk drinking*
Scores of 5 or more requires the following 7 questions to be completed

AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in last year		Yes, during last year	
					TOTAL:	

3. Your Lifestyle - Continued

Smoking					
Do you smoke?	☐ Never smoked	☐ Ex-smoker	☐ Yes		
Do you use an e-Cigarette?	☐ No	☐ Ex-User	☐ Yes		
How many cigarettes did/do you smoke a day?	☐ Less than one	☐ 1-9	☐ 10-19	☐ 20-39	☐ 40+
Would you like help to quit smoking?	☐ Yes	☐ No			
	For further information, please see: www.nhs.uk/smokefree				

Women Only	
Are you currently pregnant or think you may be?	☐ Yes ☐ No Expected due date:

Students Only			
Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see www.nhs.uk/Livewell/Studenthealth			
I am less than 24 years old and have had two doses of the MMR Vaccination	☐ Yes	☐ No	☐ Unsure
I am less than 25 years old and have had a Meningitis ACWY Vaccination	☐ Yes	☐ No	☐ Unsure

4. Further Details

Other Details				
Previous GP	Name: Address:			
If there is Social Worker involvement, please provide the contact details.	Name: Contact details:			
Country of Birth				
Ethnicity	☐ White (UK) ☐ White (Irish) ☐ White (Other)	☐ Black Caribbean ☐ Black African ☐ Black Other	☐ Bangladeshi ☐ Indian ☐ Pakistani	☐ Arabic ☐ Chinese ☐ Other

Electronic Prescribing	
If you would like your child's prescriptions to go electronically, please provide details of the pharmacy you would like to use	Pharmacy:

5. Sharing Your Health Record

Your Summary Care Record (SCR)
Do you consent to your child having an Enhanced Summary Care Record with Additional Information? ☐ Yes *(recommended option)* ☐ No

Parent or Guardian Signature	
Signature	I confirm that the information I have provided is true to the best of my knowledge
Name	
Date	

Checklist
Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed & Signed Above Form
- ☐ Completed & Signed GMS1 Form
- ☐ Birth Certificate/Red Book
- ☐ Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card*
- ☐ Proof of Address *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months*

Practice Use Only

Appointment	☐ Required	☐ Not Required		
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Council Tax	☐ Bank Statement	☐ Other
Checked by: Date:				

Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

Spa Medical Centre will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records
For further information about how the NHS uses your data for research & planning and to opt-out, please see: www.nhs.uk/your-nhs-data-matters