**Registering at Forest House Surgery**

Thank you for choosing to register with Forest House Surgery. Included in your registration pack are the necessary forms to register fully with our surgery and to aid the smooth transfer of your care and records. We have also included some useful information.

When completing your forms use a **Black Pen** and write the information in **Capital Letters.**

Please bring **All** of the following with you when return your forms to us. Failure to do so may result in your registration being delayed or even refused.

* Pink/Purple GMS1 Form
* Forest House Surgery – New Patient Registration Form
* Identification – Any of the following can be accepted as identification:
* Red Book
* Birth Certificate
* Medical Card
* Passport

**If you have recently arrived in this country, please bring your passport and or visa (as proof of residency in the UK) to confirm your date of birth and entitlement to NHS treatment.**

**Forest House Surgery**

# New Patient Registration Form – Child

**Today’s Date:**

Please complete this confidential questionnaire (one for **each** member of the family to be registered with the Practice).

Please complete in **BLACK INK** and **BLOCK CAPITALS** and tick the boxes as appropriate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** | | | | **DOB:** | |
| **Mr / Mrs / Miss / Ms / Other** | | | | **NHS Number:** | |
| **Gender: Male / Female (please circle)** | | | | **Previous Surname:** | |
| **Address and Postcode:** | | | | **Mobile Number:** | |
| **Telephone Number:** | |
| **Previous Address and Postcode:** | | | | | |
| 1. **Next of Kin:** | **Relationship of Next of Kin:** | | | | **Next of Kin contact Number:** |
| 1. **Next of Kin:** | **Relationship of Next of Kin:** | | | | **Next of Kin contact Number:** |
| **NHS Number (if known)** | | **Religion:** | | | |
| **Mother’s Name:**  **Mothers DOB:**  **Mothers Address:**  **Telephone Number:** | | **Father’s Name:**  **Father’s DOB:**  **Father’s Address:**  **Telephone Number:** | | | |
| **Previous Doctor Name, Address & Telephone Number:** | | | | | |
| **Place and Country of Birth:** | | | **First Language:** | | |

|  |  |  |  |
| --- | --- | --- | --- |
| |  | | --- | | **MEDICAL HISTORY**  **List any significant medical conditions, allergies / intolerances (ie: nuts, gluten, pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of)** | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Do you have any FAMILY HISTORY of any of the following?** | | | | | | | |  | | | | | | | | High Blood Pressure | □ Yes | Who |  | DVT / Pulmonary Embolism | □ Yes | Who | | Ischaemic Heart Disease  Diagnosed aged >60 years | □ Yes | Who |  | Breast Cancer | □ Yes | Who | | Ischaemic Heart Disease  Diagnosed aged <60 years | □ Yes | Who |  | Any Cancer  Specific Type: | □ Yes | Who | | Raised Cholesterol | □ Yes | Who |  | Thyroid disorder | □ Yes | Who | | Stroke / CVA | □ Yes | Who |  | Epilepsy | □ Yes | Who | | Asthma | □ Yes | Who |  | Osteoporosis | □ Yes | Who | | | |
| **Carer’s information:**  **A carer is a friend/family member who gives their time to support a person in their home, to an extent that a 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 able to discuss your medical information, order/collect prescriptions including controlled drugs?** | | | **Yes** |
|  | | | |
| **Is the child a carer?** | | **Yes** | **No** |
| **If yes, are they a patient at Forest House Surgery?** | | **Yes** | **No** |
| **If yes, What is their name?** | | | |
| **Are they a Friend / Relative / Neighbour (Please circle answer)** | |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Looked After Children** | | | | | |
| **Is the 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 of care 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 supervision of social services or in residential children’s homes** | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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?** | | **Who can consent for medical treatment for the child?** | |
|  | You as legal parent or guardian  Name: |  | You as legal parent or guardian  Name: |
|  | Other (please specify)  ­­­­­­­­­­­­­­ |  | Other (please specify) |

|  |
| --- |
| **Accessible Information Standard**  Communication is usually provided by the Surgery in letter and telephone form however, if you have any specific communication needs please inform a member of staff.  Please indicate below if you have any of the following disabilities:-  Partially Sighted …………………………………………………………………………………………………….  Blind ………………………………………………………………………………………………………………….  Partially Deaf ………………………………………………………………………………………………………..  Deaf ………………………………………………………………………………………………………………….  Learning Disabilities ………………………………………………………………………………………………. |

|  |
| --- |
| **Please record any additional information about you that you think is important for us to know.** |

**MY INFORMATION SHARING OPTIONS**

**Summary Care Record (SCR)**

Your SCR is an electronic summary of key medical information taken from your GP medical record. If you need healthcare away from your usual doctor’s surgery, your enhanced SCR will provide those looking after you with key information to help them give you a better and quicker care. Please refer to **‘What is a Summary Care Record’** document for more information or visit:[**https://digital.nhs.uk/summary-care-records/patients**](https://digital.nhs.uk/summary-care-records/patients)

**Tick this box if you wish to have an enhanced SCR with core and additional information (recommended) □**

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

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**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.healthcare gateway.co.uk/products

**Tick this box if you wish to opt-out of the MIG data sharing** □

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**Risk Stratification Preferences**

Risk stratification is the process of identifying the relative risk of patient in the population by analysing their medical history. It’s a key enabler for improving the quality of care delivered by the NHS. **Forest House Surgery** is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using Risk Stratification will only see anonymised data.

**Tick this box if you wish to opt-out of the Risk Stratification Programme** □

**Contacting you by Telephone or Text Messaging**

Do you consent to receive the following types of communication from **Forest House Surgery**:-

**Please tick:**

Mobile phone text messages.

**Yes** □ **No** □

**Please tick:**

Answering machine or voicemail messages**.**

**Yes** □ **No** □

|  |
| --- |
|  |

**Application for Systmone online access**

|  |  |
| --- | --- |
| Surname: | Date of birth: |
| First name: | |
| Address:      Postcode: | |
| Email address: | |
| Telephone number: | Mobile number: |
| The following access will be provided as **Standard** | |

|  |
| --- |
| Booking appointments |
| Requesting repeat prescriptions |
| Accessing my brief summary care record (Current medication, allergies, adverse reactions) |

**Additional access**

(please tick if required)

|  |  |
| --- | --- |
| Access **prospective** coded data from my medical record. | tick |
| When accessing my summary care record and / or prospective coded data online I understand and agree with each statement.  (Please tick the following) | |
| I will be responsible for the security of the information that I see or download | tick |
| If I choose to share my information with anyone else, this is at my own risk |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |

Failure to agree to all of the above conditions will unfortunately mean we are unable to agree to your request for access.

**Important Login Details Information**

If applying for internet access, at the same time that you are registering with the Surgery, your login details and password will be **sent to you via a text message** to your mobile phone number.

If you have not given us a mobile number the information will be left securely at our reception desk for you to collect. This will be available two working days after you have given us your registration forms and destroyed if not collected within two weeks. You will need to **bring the same ID** with you to collect these details as used for registration. If you collect after two weeks a new form will need to be completed and a new password generated.

|  |  |
| --- | --- |
| Signature: | Date: |

**For practice use only**

|  |  |
| --- | --- |
| Identity verified by  (Name) | Method  Passport/Driving Licence 🞏  Non-Photo ID 🞏  Proof of residence 🞏  Parent ID (Under 14) 🞏 |
| Date account created : | |

**This page is for all Young People Aged 13 and Older ONLY**

**In accordance with the Data Protection Act, the practice needs consent if you would like to nominate a third party to act on your behalf. Please give their details below:-**

**Nominated Person/s**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | | |
| **Address** |  | | |
| **Telephone Number** |  | **Relationship to Patient** |  |
| **The above person can:** | | | **Tick all that apply** |
| Discuss my medical records and any appointments on my behalf | | |  |
| Order and collect my prescriptions (Not Controlled Drugs) | | |  |
| Order and collect my **controlled drug** prescriptions | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | | |
| **Address** |  | | |
| **Telephone Number** |  | **Relationship to Patient** |  |
| **The above person can:** | | | **Tick all that apply** |
| Discuss my medical records and any appointments on my behalf | | |  |
| Order and collect my prescriptions (Not Controlled Drugs) | | |  |
| Order and collect my **controlled drug** prescriptions | | |  |

***What is your Ethnic Group?***

|  |  |  |
| --- | --- | --- |
| ***A White*** | ***British*** |  |
| ***B White*** | ***Irish*** |  |
| ***C White*** | ***Any other white background*** |  |
| ***D Mixed*** | ***White and Caribbean*** |  |
| ***E Mixed*** | ***White and Black African*** |  |
| ***F Mixed*** | ***White and Asian*** |  |
| ***G Mixed*** | ***Any other mixed background*** |  |
| ***H Asian or Asian British*** | ***Indian*** |  |
| ***J Asian or Asian British*** | ***Pakistani*** |  |
| ***K Asian or Asian British*** | ***Bangladeshi*** |  |
| ***L Asian or Asian British*** | ***Any other Asian background*** |  |
| ***M Black or Black British*** | ***Caribbean*** |  |
| ***N Black or Black British*** | ***African*** |  |
| ***P Black or Black British*** | ***Any other black background*** |  |
| ***R Other ethnic groups*** | ***Chinese*** |  |
| ***S Other ethnic groups*** | ***Any other ethnic group*** |  |

**Patient Signature: …………………………………………………………………………………………….………….**

**Signed on behalf of patient: ………………………………………………………………………………………….**

**(if applicable)** for minors under 16 years old or adults lacking capacity

**Date: …………………………………………….**

**Thank you for completing this form**

***For more information about the services we offer, please refer to your new patient pack  
 or see our website: www.foresthousesurgeryshepshed.co.uk***