CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Name:

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

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: _____ Phone number _____

Address: _____ Mobile Number: _____

Relationship: _____

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read overleaf the leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the boxes below and read the form attached.

Title …… **Given Name** …….... **Surname** …….

Post Code ……. …… **House Number** ……..

Signature …… **Date** ……..

Please **opt me out** of sharing my record from the practice with others involved in my care *(9NDO)*: ☐
Please **opt me out** of sharing my record with other NHS organisations for unplanned care **Summary Care Record** *(9NDQ)*: ☐
Please **opt me out** of my health data leaving the GP practice for **Care.Data** *(9Nu0)*: ☐

Patient Reference Group

The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for making services better. We send information emails regarding the practice such as our quarterly newsletter and also pertinent information about local health services. At times we will also request feedback and a response from patients. You are in no way obliged to respond but it does help us to develop our services for you. If you provide us with your email address we will automatically add you to the group unless you tell us not to.

No, I am not interested in receiving information from the practice or being part of the Practice Patient Reference Group (Please tick the box) ☐

Communications: if it is ok for us to leave messages on your home answerphone please tick:

What is your preferred contact method: □ text □ email □ letter □ phone call

Do you have special communication needs? □ braille ☐ large print ☐ interpreter ☐ easy read

☐ lip reading ☐ speech to text reporter (STTR) ☐ advocate ☐ British Sign Language BSL

If you need interpretation, what is your first language? ☐

Signature ……

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

Signed: ☐ Date: ☐

Signature of patient ☐ Signature on behalf of patient ☐