**Stratford Health Centre – Child New Patient Registration Form**

**To be given to: 0 - 15 years old**

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| --- | --- | --- | --- |
| Name: |  | D.O.B: |  |
| Main Language: |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **\*Ethnicity - Please Tick** | | | | | |
| African |  | Black British |  | British Bangladeshi Or Bangladeshi |  |
| British Indian Or Indian |  | British Or Mixed British |  | British Pakistani Or Pakistani |  |
| Caribbean |  | Estonian |  | Latvian |  |
| Lithuanian |  | Other White Background |  | White British |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

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| --- | --- | --- |
| **Do You Have Any Medical Conditions?** | **Yes / No** | **If YES, Please List:** |
|  | | |

|  |  |  |
| --- | --- | --- |
| **Do You Have Any Allergies?** | **Yes / No** | **If YES, Please List:** |
|  | | |

|  |  |  |
| --- | --- | --- |
| **Do You Take Any Medication?** | **Yes / No** | **If YES, Please List:** |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\***Height: |  | **\***Weight: |  |

|  |  |
| --- | --- |
| **Are You A Carer?** | |
| **\***Name Of Person You Are Caring For? |  |
| **\***Contact Number Of Person You Are Caring For? |  |
| **\***Relationship To Person You Are Caring For? |  |
| **Do You Have A Carer?** | |
| **\***Name Of Person Who Cares For You? |  |
| **\***Contact Number Of Person Who Cares For You? |  |
| **\***Relationship To Person Who Cares For You? |  |

**For Office Use Only**

|  |  |
| --- | --- |
| **Has the patient selected a Pharmacy nomination for EPS?** | **Yes / No** |
| **Name of Pharmacy:** |  |

|  |  |
| --- | --- |
| **ID Check** | **Immunisations** |
| Have you taken a copy of the patients Birth Certificate / Passport and immunisation history and stapled it to this registration form?  Yes  / No | Have you taken a copy of the patients red book and immunisation history and stapled it to this registration form?  Yes  / No |

**IF THE MOTHER IS REGISTERING THE CHILD**

|  |  |
| --- | --- |
| Is the mother registered at the practice? | Yes  / No |
| If yes, please provide the mothers EMIS Number: | EMIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If no, please advise the person registering the child that the Mother will either;   * Need to register with The Forest Practice before we can register the child   Or   * The child needs to be registered at the same practice as the Mother | |

**IF THE FATHER IS REGISTERING THE CHILD**

|  |  |
| --- | --- |
| Is the father registered at the practice? | Yes  / No |
| If yes, is the fathers name listed on the Birth Certificate? | Yes  / No |
| If no, is the mother registered at the practice? | Yes  / No |
| If yes, please provide the mothers EMIS Number: | EMIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If no, please advise the person registering the child that we cannot register the child or that they need to;   * Register the child at the same practice as the Mother | |

**IF THE FOSTER CARER OR GUARDIAN IS REGISTERING THE CHILD**

|  |  |
| --- | --- |
| Does the foster carer or guardian have documented evidence that they are legally looking after the child? | Yes  / No |
| If yes, please take of register the child | |
| If no, please advise the person registering the child that they need to provide evidence that they are legally responsible for the child. | |

|  |  |
| --- | --- |
| **Has the patients Summary Care Record been coded?** | **Yes / No** |
| **Has Accountable/Named General Practitioner Codes added? 67DJ and 9NN60** | **Yes / No** |

|  |  |
| --- | --- |
| Is this registration complete and have all patient details been entered and coded onto EMIS?  **Yes / No** | |
| **Administrator Name:** | **Date:** |
| **PLEASE REMEMBER TO PUT THIS REGISTRATION FORM INTO THE SCANNING TRAY, ONCE IT HAS BEEN COMPLETED.** | |



# Your emergency care summary

**Information for new patients: about your Summary Care Record**

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

* **Express consent for medication, allergies and adverse reactions only.**

You wish to share information about medication, allergies for adverse reactions only.

* **Express consent for medication, allergies, adverse reactions and additional information.**

You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

* **Express dissent for Summary Care Record (opt out).**

Select this option, if you DO NOT want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice. Please return this form to the practice as soon as possible.

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# Your Emergency Care Summary

**Summary Care Record patient consent form**

Having read the above information regarding your choices, please choose one of the options below and return the completed form to your GP practice:

**Yes – I would like a Summary Care Record**

Express consent for medication, allergies and adverse reactions only.

**OR**

Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

Express dissent for Summary Care Record (opt out).

Name of patient: ………………………………………………..….........................

Date of birth: ………………………………………………………………………. Patient’s postcode: ……………………………………………

Surgery name: …………………………………………………………………….. Surgery location (Town): ……….................. …………

NHS number (if known): …………………………..………………................................... ………………………………………………………

Signature: ……………………………………………………………………………… Date: ………………………………………………………………….

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ………….........................................................................................................

**Please CHECK one:**

**PARENT**

**LEGAL GUARDIAN**

**LASTING POWER OF ATTORNEY FOR HEALTH AND WELFARE**

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

To update the patient’s consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

|  |  |  |
| --- | --- | --- |
| **Summary Care Record consent preference** | **Read 2** | **CTV3** |
| The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only) | 9Ndm. | XaXbY |
| The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn. | XaXbZ |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo. | XaXj6 |

**Updated 09.03.2019**