|  |  |  |
| --- | --- | --- |
| **Name:** | **DoB:** | **Date:** |
| **Parent/Guardian:** |

**The practice needs your express consent to use your data to help manage your care. The practice strongly recommends that you sign sections 1, 2 and 3 which will ensure you continue to receive the highest quality of health care.**

**\*Data Sharing**

|  |
| --- |
| **1. Summary Care Record (SCR)**The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information, which includes: current medication, any allergies and any bad reactions to medication.**Please sign if you wish to opt-in of the Summary Care Record.** Signature: …………………………………………… |
| **2. Enhanced Summary Care Record** This is the same as above where other important information can be shared i.e. Any health issues, illnesses, operations, vaccinations, next of kin or what support you may need. Expressed consent given Signature: ……………………………………………  **Please sign if you wish to opt-in of the Enhanced Summary Care Record** XaXbZ   |

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| **3. Risk Stratification Preferences****Risk stratification** is the process of identifying the relative **risk** of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Risk Stratification programme allows uploading of patient’s 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. **Please sign if you wish to opt-in of the Risk Stratification programme .** Signature: ……………………………………………… (XabjB)**For more information please visit our website at** [**www.theglenfieldsurgery.co.uk**](http://www.theglenfieldsurgery.co.uk) |

**The practice has no particular view as to whether you should consider sections 4 and 5**.

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| **4. Medical Interoperability Gateway (MIG)**Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.**For more information please visit the “Further Information” page on our website at:** [**www.theglenfieldsurgery.co.uk**](http://www.theglenfieldsurgery.co.uk)**Please sign if you wish to opt-in of the Medical Interoperability Gateway .** Signature: …………………………………………………….. |

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| **5. . Care Data**Care data is anonymised data used by the Health Service and other agencies to plan care for population. Data of this type is used primarily for planning purposes. Further information is on our website ([www.theglenfieldsurgery.co.uk](http://www.theglenfieldsurgery.co.uk)). Care Data information leaflets are available on the NHS England website ([www.england.nhs.uk/ourworks/tsd/care.data/](http://www.england.nhs.uk/ourworks/tsd/care.data/)). Patients who agree have their information automatically extracted from their patient record by the Health & Social Care Information Centre. **Please sign if you wish to opt-out of the Data Care Information.** Signature: ………………………………………… XaZ89 |

Groby Surgery – Child Registration Form.

(Under 16 years old)

Tel: 0116 2333600, Web: www.theglenfieldsuregery.co.uk

Thank you for applying to join The Groby Surgery. We would like to gather some information about you 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 you the best possible care. **Please provide proof of address.**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure an adult **SIGNS** and **DATES** this form.

**Fields marked with an asterisk (\*) are mandatory.**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Title | \*Surname |  | \*First & other names |
| Calling Name: |  | \*Date of Birth |
| \*[ ] Male [ ] Female |  | NHS No. [ ] [ ] [ ]  [ ] [ ] [ ]  [ ] [ ] [ ] [ ]  |
| Town and Country of birth: |  | \*Home address\*Postcode: |
| School (if appropriate): |  |
| Has the child registered with a G.P. previously? [ ] Yes [ ] No |  | \*Home telephone No. |
| \*Is the child a looked after child? [ ] Yes [ ] NoA **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. |  | Contact Mobile No.As a practice we will send text messages where appropriate, if you wish NOT to receive texts [ ] No |
| Relationship to child: |

**\*Additional details about the child**

|  |
| --- |
| \*Ethnic group?Previous G.P. / Surgery:**White** [ ]  British [ ]  Irish [ ]  Other White (please specify):**Black** [ ]  Caribbean [ ]  African [ ]  Other Black (please specify):**Asian** [ ]  Indian [ ]  Pakistani [ ]  Other Asian (please specify):**Mixed** [ ]  White & Black Caribbean [ ]  White & African [ ]  White & Asian |

|  |
| --- |
| If their preferred spoken language is NOT English please indicate what it is |

**A ‘carer’ is someone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem**

 **or an addiction cannot cope without their support.**

|  |
| --- |
| Is the child Cared for? [ ] Yes [ ] No Name & Relationship: Their contact details: ( 918F) |
|  Is the child a Carer? [ ] Yes [ ]  No (Ub1ju)If yes, do they look after someone who is a patient of The Glenfield Surgery? [ ] Yes [ ] No [ ]  Don’t know |
| Is the child Fostered? [ ] Yes [ ]  No Has the child been Adopted? [ ] Yes [ ]  No Foster/Adoptive Parent’s Names |

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**Next of kin / Emergency Contact**

|  |  |  |
| --- | --- | --- |
| Name of next of kin/Emergency contact |  | Relationship to Child |

|  |  |  |
| --- | --- | --- |
| Next of kin/Emergency telephone number(s) |  | Next of kin address (if different to above) |

**\*Medical details**

|  |  |  |
| --- | --- | --- |
| Does the child have any special needs regarding information or communication, (e.g. Deaf or visual impairment) Please give details. |  | Do they communicate using BSL/deafblind manual/other: |
| Do they communicate using hearing aids / talking mat/other: |

|  |  |  |
| --- | --- | --- |
| If we need to contact you which would be the best way is text/ phone/ letter/ other |  | Do they need information in large print / braille/other: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Epilepsy** | [ ]  Yes  | Year |  | **Mental Illness** | [ ]  Yes  | Year |
| **High Blood Pressure** | [ ]  Yes  | Year |  | **Diabetes** | [ ]  Yes  | Year |
| **Heart Attack / Angina** | [ ]  Yes  | Year |  | **Asthma** | [ ]  Yes  | Year |
| **Stroke / Mini-stroke (TIA)** | [ ]  Yes  | Year |  | **COPD (or Emphysema)** | [ ]  Yes  | Year |
| **Cancer** | [ ]  Yes  | Year |  | **Osteoporosis / Bone fractures** | [ ]  Yes  | Year |
| **Rheumatoid Arthritis** | [ ]  Yes  | Year |  | **Peripheral vascular disease** | [ ]  Yes  | Year |

**Has the child ever had any of the following conditions?**

None of the above conditions yes

The child is NOT currently on any repeat medication yes

|  |
| --- |
| List any serious illnesses / operations / accidents (Females: any pregnancy related problems) & the year they took place: |
| Does the child have any disabilities (whether they are registered disabled or not) |
| Physical Disability – Please describe: | Learning Disability – Please describe: |

|  |
| --- |
| **Repeat Medication Information –** Please attach a repeat prescription request form from your previous G.P. if you have one. |
| **Name of Medication** | **Strength (mg)** | **How Often Medication is taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

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| --- |
| \* Is the child allergic to any medicines? [ ]  Yes [ ]  No (if yes please specify) |
| \*List other allergies (pollen, animal hair or certain foods. Please mark “none” if they have no other allergies that you know of) |

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**\*Smoking Data \*\*we are required to collect this data\*\***

|  |  |  |
| --- | --- | --- |
| If the child is **14 or over and asthmatic** does he/she smoke? [ ]  Yes [ ]  NoHow many do you smoke a day? |  | If the child is **15 or over** does he/she smoke? [ ]  Yes [ ]  NoHow many do you smoke a day? |

|  |
| --- |
| The best way of stopping smoking is with a combination of medication and support. For details of ‘Smoking Cessation’ clinics please call 03456466666. |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **High Blood Pressure** | [ ]  Yes  | Who |  | **DVT / Pulmonary Embolism** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged >60 yrs | [ ]  Yes  | Who |  | **Breast Cancer** | [ ]  Yes  | Who |
| **Ischaemic Heart Disease**Diagnosed aged <60 yrs | [ ]  Yes  | Who |  | **Any Cancer**Specify type: | [ ]  Yes  | Who |
| **Raised Cholesterol** | [ ]  Yes  | Who |  | **Thyroid disorder** | [ ]  Yes  | Who |
| **Stroke / CVA** | [ ]  Yes  | Who |  | **Epilepsy** | [ ]  Yes  | Who |
| **Asthma** | [ ]  Yes  | Who |  | **Osteoporosis** | [ ]  Yes  | Who |

None of the above conditions yes

**IMMUNISATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunisation**  | **Date(s) Given** | **Immunisation** | **Date(s) Given** |
| **Diphtheria** |  | **MMR** |  |
| **Polio** |  | **BCG** |  |
| **Pertussis** |  | **Other (specify)** |
| **HIB** |  |

|  |
| --- |
| **Please record any additional information about the child that you think may be important for us to know** |

We aim to have patient’s registered within 2-3 working days or less but, due to practice workloads this may take up to 5 working days.

If there are any problems with your registration we’ll contact you to clarify any issues.

|  |  |  |
| --- | --- | --- |
| **To be signed by an adult on behalf of patient.** (Patient is a minor/under 16 years old)**Name:****Signature:****Relationship to patient:** |  | **Date** |

|  |
| --- |
| **FOR OFFICE USE ONLY** |
| **ADDRESS ID [ ]  TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Staff Name:…….………….…………………….. Date Accepted:………………………………….** **Checked by: ……………………………………… Date: ………………………………………………..** |

Jul 22