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| Full Name (including middle): Date of Birth: | | | |
| Please state your child’s birth gender?  Male  Female  Is your child’s gender identity the same as the sex they were assigned at birth?  Yes  No  Prefer not to say | Mother’s Full Name:  Mother’s Date of Birth:  Father’s Full Name:  Father’s Date of Birth: | |  |
| **NEXT OF KIN** | | | |
| Name: | Contact Tel No: | Relationship to Patient: |  |
| Does your child have a Carer?  Yes  No *If yes, please give carer’s details* | | | |
| Name: | | Contact Details: | |
| **CONTACT DETAILS** | | | |
| Email:  Wherever possible we prefer to send out information via email, this will include your new patient registration information and your Patient Access PIN document, should you choose to sign up to the service.  Are you happy to receive emails from us?  Yes  No | | Mobile:  We offer an appointment reminder SMS messaging system. This will also include general health information and Practice information such as changes to opening times, simple health status questions and recalling patients for chronic disease management.  Are you happy to receive SMS messages from us?  Yes  No | |
| Please state your preferred method of contact:  Email  SMS (text)  Mobile Tele.  Home Tele (please state)………………………………. | | | |

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| **ONLINE SERVICES** | | |
| **Patient Access (Proxy User)**  We offer online services to all patients, this can be accessed via Patient Access or the NHS app. This allows you to;   * Order repeat prescriptions * Change your contact details * View your full medical record (from date of registration onwards)   You can sign your child up for this service dependant on their age;   * Aged 0-11 years – parent/guardian can have full access if required * Age 11 – 15 years – parent/guardian can only have access to medications and basic summary   If you wish to subscribe to this service, please complete the Proxy Access form on page 6. | | |
| **PREVIOUS DETAILS** | | |
| So we can ensure that we have your child’s full medical record, please provide us with any previous names your child may have held, your child’s last three addresses in the UK and your child’s last three GP surgery addresses (if applicable).  It is vital that we have your child’s full medical record, this is important so we can maintain screening programmes, provide your child with the best care and keep your child’s medical records complete.  Primary Care Service England (PCSE) will pause your child’s registration with the practice if they find a possible match to your child’s demographics on the NHS Spine, therefore providing us with this information now can prevent this from happening. | | |
| PREVIOUS NAME(S): | | |
|  | | |
| PREVIOUS ADDRESS(ES): | | |
|  |  |  |
| PREVIOUS GP PRACTICE(S): | | |
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| **PUBLIC HEALTH STATISTICS** | | | | | |
| **Your Child’s Religion** | | | | | |
| Buddhist  Hindu  Muslim | | Catholic  Jehovah’s Witness  No religion | | Christian  Jewish  Other: | |
| **Your Child’s Ethnic Origin** | | | | | |
| White British  Black African / British  Arabic  Other Mixed Background | White Irish  Other Black Background  Bangladeshi / British  Other, please state: | | White Other  Indian / British Indian  Chinese | | Black Caribbean / British  Pakistani / British  Other Asian Background  Ethnic Category Refused |
| **What is your child’s main spoken language?**  *Please state below;* | | | **Do you or your child use an Interpreting app on your phone?**  **Yes**  **No**  **Does your child require an Interpreter present at appointments?**  Yes  No | | |
| **Does your child speak English?**  Yes  No | | |

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| **HEALTH INFORMATION** | | | |
| **Weight:** | **Height:** | **How much exercise does your child do?** | |
| None | Light |
| Moderate | Vigorous |
| **YOUR CHILD’S MEDICAL BACKGROUND** | | | |
| **Does your child have any disabilities?** | | | |
| **Does your child have any drug or food allergies? Please list:** | | | |
| **Does your child have any major health issues you wish the doctor to be aware of? Please list:** | | | |

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| **REPEAT MEDICATIONS** | | | | | |
| **Is your child taking any regular medications? If so please give details in the box below;**  *If your child is taking more than 5 repeat medications, please attach a list.* | | | | | |
| **Medication Name**  (Generic not branded) | | | **Dosage** | | **Quantity left** |
|  | | |  | |  |
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| **! IMPORTANT INFORMATION REGARDING MEDICATIONS !**   * Your child MUST have a medication review before we are able to issue any medications. An appointment will be sent to you via SMS or letter following your child’s registration. * If you are coming from abroad, please have your child’s medication information translated and provide evidence that your child is taking this medication with their registration papers. | | | | | |
| **We now send prescriptions electronically (EPS) to a Pharmacy of your choice. Please pick your desired Pharmacy below;** | | | | | |
| Rowlands  Boots Hale Leys  Hampden Gardens  Pharmacy 2 U | Consult  Boots Walton Court  Buckingham Park  Other: | Tesco Tring Road  Morrisons  Lloyds Bedgrove | | Tesco Broadfields  Lansdale  Lloyds Meadowcroft | |

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| **IMMUNISATIONS** | | | |
| If your child is coming from abroad and this is their first registration at the practice, please complete the immunisation chart below.  *NB: If you choose to attach copies of your child’s immunisations please have these translated prior to registration.* | | | |
| **Approximate Age** | **Immunisation** | **Date given** | **Country given** |
| **8 weeks** | 1st Diphtheria, Tetanus, Pertussis |  |  |
| 1st Polio |  |  |
| 1st HIB |  |  |
| 1st Pneumococcal |  |  |
| 1st Rotavirus |  |  |
| 1st Meningitis B |  |  |
| **12 weeks** | 2nd Diphtheria, Tetanus, Pertussis |  |  |
| 2nd Polio |  |  |
| 2nd HIB |  |  |
| 2nd Rotavirus |  |  |
| 1st Meningitis C |  |  |
| **16 weeks** | 3rd Diphtheria, Tetanus, Pertussis |  |  |
| 3rd Polio |  |  |
| 3rd HIB |  |  |
| 2nd Pneumococcal |  |  |
| 2nd Meningitis B |  |  |
| **12 months** | HIB/Men C Booster |  |  |
| 1st MMR (Measles, Mumps, Rubella) |  |  |
| 3rd Meningitis B |  |  |
| 3rd Pneumococcal |  |  |
| **3 years, 4 months** | MMR Booster |  |  |
| Diphtheria, Tetanus, Pertussis & Polio Booster |  |  |
| **12 years upwards** | HPV |  |  |
| MenACWY |  |  |
| **FAMILY HISTORY** | | | |
| **Does your child have a family history of any of the following?**  Diabetes Mellitus  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Heart Attack  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Stroke  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Angina  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Hypertension (High Blood Pressure)  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Breast Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Ovarian Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Bowel Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Lung Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Any other form of Cancer (please state): ..………………………………………………………………………………………………. | | | |

**Online services application for Proxy User Access**

**e.g. Children under 16 years of age/carers/family members.**

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| **Patient for which access is being requested** | | | | | | | | | | | |
| Title |  | | | First Name |  | | Last name | | |  | |
| Gender | | Male/Female | | | | | Date of Birth | | |  | |
| Address | | | |  | | | | | | | |
| **TO BE COMPLETED BY PATIENT** | | | | | | | | | | | |
| **I give permission to Poplar Grove Practice to give the below named individual/s proxy access to the online services as indicated below.**  **I reserve the right to reverse any decision I make in granting proxy access at any time.**  **I understand the risks of allowing someone else to have access to my health records and I have read and understood the information leaflet provided by the practice.** | | | | | | | | | | | |
| I grant permission to allow access to book appointments and order repeat prescriptions only | | | | | | | | | | |  |
| I grant permission to allow access to book appointments, order repeat prescriptions and view  online medical records | | | | | | | | | | |  |
| **\*Signature** | | |  | | | | | **Date** |  | | |
| Name and relationship (if signed on behalf of patient) | | | | | |  | | | | | |

\*If the patient does not have capacity to consent this should be signed by the person holding lasting power of attorney for health and welfare or by the GP.

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| **Proxy Users applying for access** | | | | | | | |
| Title |  | | First Name | |  | Last name |  |
| Gender | | Male/Female | | | | Date of Birth |  |
| Address | | |  | | | | |
| Email | | |  | | | | |
| Relationship to Patient | | | |  | | | |
| Title |  | | First Name | |  | Last name |  |
| Gender | | Male/Female | | | | Date of Birth |  |
| Address | | |  | | | | |
| Email | | |  | | | | |
| Relationship to Patient | | | |  | | | |

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| **TO BE COMPLETED BY THE PROXY USER/USERS APPLYING FOR ACCESS** | | | | |
| **I/we understand my/our responsibility for safeguarding sensitive medical information and understand and agree with the following statements *(please tick to indicate agreement):*** | | | | |
| I/we will be responsible for the security of the information that I/we see or download. | | | |  |
| I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by  someone without the patient’s agreement. | | | |  |
| If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the practice as soon as possible, I/we will treat any information which is not about the patient as being strictly  confidential. | | | |  |
| **Signature** |  | **Date** |  | |
| **Signature** |  | **Date** |  | |