

NEWBATTLE MEDICAL PRACTICE

REGISTRATION ADVICE SHEET - CHILD

To allow us to process your registration efficiently with Newbattle Medical Practice and NHS Lothian, please complete **ALL** sections of the attached forms and return to us with the following items of identification:

1. Proof of identification = ONE of the following:
 - Valid passport
 - NHS Medical Card
 - Birth Certificate

If you don't have any of the above, please speak to a receptionist who will be happy to advise what we may accept instead.

Newbattle Medical Practice

New Patient Questionnaire for Children Under 16 Years

Please complete one form for every child that you are registering with the practice and return it to reception. Children are not routinely offered a New Patient Medical consultation however we do still require some basic information.

Some children *will* be offered a consultation, depending on their medical background. Please inform the receptionist if you think that your child would benefit from seeing a doctor or nurse.

Please let the receptionist know if you have any difficulty completing this form.

Date form completed:

Part 1 Personal information

Child's name:	Date of birth:
Address (including postcode):	Home telephone number:
School or nursery attended:	
Previous Address:	Name and address of previous GP:

It is very useful for us to be able to link family records.

Please list below the names and dates of birth of all adults who have parental responsibility for this child. Please indicate if the adult lives at the same address as noted above.

Forename	Surname	Date of birth	Relationship to child	Same address?

Part 2 Medical information

Prescribed medication: please list any medications that your child takes regularly (or attach the repeat prescription list from your previous GP)

Drug name	Strength	Dose instructions	Illness prescribed for
<i>eg loratadine</i>	<i>10mg</i>	<i>1 tab in the morning</i>	<i>hayfever</i>
.....
.....
.....
.....

Allergies (please state drug name and type of reaction eg rash, nausea, severe collapse):

Immunisation dates (please use exact dates or let us copy the page from your parent held record):

Diphtheria					
Tetanus					
Pertussis					
Polio					
Hib					
Pneumococcal					
Meningitis C					
MMR					

Other (eg BCG, hepatitis B, travel vaccines):

Any additional information that you think is relevant:

Office use only:
Date of registration:
Date records assessed and coded (38B.):
Coded (13IF.): yes / no ...and other associated records updated Date.....
Date Family List completed and filed (if necessary):
Date ID field updated for all family members:
Date offered new patient consultation and coded (90h.):
Date completed new patient consultation and coded (90h6.):

Part 3 Ethnicity

Name

Address

.....

.....

Date of Birth

The NHS is committed to helping all ethnic groups. In order to help the NHS pinpoint aid, would you please complete the following question. If you do not wish to divulge your ethnicity, please tick the box at the bottom of the page.

What is your ethnic group?

Choose one section from A to E, and then tick the appropriate box to indicate your ethnic group.

A: White

- Scottish
- Other white British
- Irish
- Any other white background (please specify).....

B: Mixed

- White and black caribbean
- White and black african
- White and asian
- Any other mixed background (please specify).....

C: Asian or asian British

- Indian
- Pakistani
- Bangladeshi
- Any other asian background (please specify).....

D: Black or black British

- Caribbean
- African
- Any other black background (please specify).....

E: Chinese or other ethnic group

- Chinese

- Any other (please specify)

- Do not wish to divulge ethnicity

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE



1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male* Female* Is this your first registration with a GP Practice in the UK?* Yes No Will you be in the area for more than 3 months?* Yes No
(If 'No', please ask for form GMSTRF001)

Date of Birth* - -

Title*

Surname*

Forenames*

Previous Surname*

email address #

Address*

Postcode*

Telephone #

Mobile #

The following information can be found on your current medical card:

Community Health Index (CHI) Number* NHS Number*

The following information can be found on your birth certificate:

Town of Birth* Country of Birth*

Registered district of birth (Scotland only) Mother's maiden name

the data supplied in these fields will not be input to, or updated in, the Community Health Index (CHI), but will be held on the GP Practice's system

2. HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWING INFORMATION

Address in UK when you were last registered with a GP*

Name and address of previous GP Practice in UK*

Postcode* Postcode*

If you are from abroad:

Date you first came to live in the UK* - - If previously resident in the UK, date of leaving* - -

Your most recent country of residence

If you have served in the British Armed Forces:

Enlistment date* - -

Are you a Reservist?* Yes No

Leaving date* - -

Is this your first registration with a GP since leaving the Armed Forces?* Yes No

Service Number

If yes, please provide your address before enlisting*

Postcode*

3. VOLUNTARY CONSENT TO ORGAN DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1 including your name, gender, date of birth address and CHI number. For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonation.nhs.uk.

Any of my organs and tissue Or my

Kidneys Eyes Heart Lungs Liver Pancreas Small bowel Tissue

Patient signature _____ Date - -

4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.

Your information, including your name, gender, date of birth and address, will be passed to NHS National Services Scotland where it will be held on the Community Health Index (CHI). This information is used to register you with the GP Practice, transfer your medical records between GP practices in the UK, make payments to GP Practices for medical services provided, and to process and issue medical cards, medical exemption certificates and entitlement cards.

NHS National Services Scotland shares information about you within NHSScotland to assist in the provision and improvement of NHS services and the health of the public. When we do this, we make sure that the information which identifies you as a person and your health information are separated or anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS National Services Scotland uses your personal information visit www.nhsnss.org. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality – it's your right', visit the Health Rights Information Scotland website at www.hris.org.uk or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

5. PATIENT DECLARATION

I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate action may be taken.

To enable NHS National Services Scotland to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, relevant information from this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

Patient/Patient's representative signature _____ Date - -

Representative's name (if applicable)

Relationship to patient (if applicable)

6. FOR PRACTICE USE

GP reference number - GP name

Practice code - Mileage (No.) Road Water Footpath

Identification seen - do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of identification is seen to positively identify the applicant)

Birth Cert. Student ID Card Driving Licence Passport or HC2 Cert. Home Office App Reg Card Other/None - specify Receptionist initials

I accept this patient onto the practice list and declare that, to the best of my knowledge, this information is correct. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be subject to Payment Verification.

Authorised Practice signature _____ Date - -

7. OFFICIAL USE ONLY

Input by

Checked by

Date - -

Practice Stamp