

For staff use only:
 Correctly filled in Y/N
 ID Checked Y/N
 Address in area Y/N
 Received By :

CRANESWATER GROUP PRACTICE

NEW PATIENT REGISTRATION FORM - UNDER 14 YEARS OLD

SUMMARY CARE RECORDS: (If you do not tick a box it will automatically happen)

The NHS England is introducing the Summary Care Record, which will be used in emergency care.
 The record will contain information about any medications you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- YES I would like my summary care record** - you do not need to do anything and a Summary Care Record will be created for you.
- NO I do not want a Summary Care Record** -Please ask a member of reception for a form to fill in.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP Practice.

SHARING DATA IN & OUT: (If you do not tick a box it will automatically happen)

Do you consent to the sharing of data recorded here with any other organisations i.e. physiotherapy that may care for you?

- YES** **NO**

Do you consent to the viewing of data by this organisation that is recorded at other care services i.e. physiotherapy that may care for you where you have agreed to make the data shareable?

- YES** **NO**

Signed on behalf of patient

Print Name

Relationship to child

Date

Surname	
Forenames	
Date of Birth	
NHS Number	
Male/Female	
Address	
Postcode	
Place of Birth	
Telephone Number(s)	
Email Address	
Previous Surgery Address & Doctor	
Next of Kin Name	
Relationship to you	
Next of Kin Telephone Number(s)	
Is your next of kin registered at this practice?	YES / NO

ETHNIC ORIGIN :

African		Other Black Background	
Bangladeshi		Other Mixed Background	
British OR Mixed British		Other White Background	
Caribbean		Pakistani	
Chinese		White & Asian	
Irish		White & Black African	
Indian		White & Black Caribbean	
Other Asian Background		I Do Not Wish To Give My Ethnic Origin	

Religion			
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First/Main Language Spoken?			
Do you need an Interpreter?	YES / NO		
Are you from abroad?	YES / NO	Date you first came to live in the UK	

ABOUT YOU:

Height		Weight	
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VACCINATION	DATE ADMINISTERED
1st - Diphtheria/Tetanus/Polio/Hib/Pertussis	
2nd - Diphtheria/Tetanus/Polio/Hib/Pertussis	
3rd - Diphtheria/Tetanus/Polio/Hib/Pertussis	
1st Pneumococcal	
2nd Pneumococcal	
1st Meningitis C	
2nd Meningitis C	
Hib/Men C Booster (Given at 12 months)	
Pneumococcal Booster (Given at 12 months)	
1st MMR (Given at 12 months)	
2nd MMR	
Pre School Booster	
School Leavers	

FAMILY HISTORY :

CONDITION	YOU	OTHER FAMILY MEMBER & RELATIONSHIP TO YOU
Stroke		
Raised Blood Pressure		
Heart Disease		
Diabetes		
Asthma/ Respiratory Problems		
Mental Health Problem		
Thyroid Problem		
Epilepsy		
Cancer (please state, e.g. Bowel etc)		

YOUR MEDICAL HISTORY :

PAST MEDICAL HISTORY (Operations etc)

ALLERGIES

ARE YOU ON ANY REPEAT MEDICATION? (Please include HRT OR Contraceptive Pill) <i>-Please note, you will need to see a Doctor before you can be issued with a repeat prescription</i>
Would you like your prescriptions to go electronically to a pharmacy? YES / NO
If yes, Please specify the pharmacy & its address :