Only complete if applicable
Foster Carers Details: Name: DOB: Address: Contact Tel No: **Are you also registered at Chatsworth Road Medical Centre? Yes ( ) No ( )**

Thank you for taking the time to complete this questionnaire. Please hand your completed registration forms back to a receptionist to check we have all the relevant information to process your registration.

For Office Use Only:	
Nurse Appointment How Long / which nurse?	
Dr Appointment	
Pass to Health Visitors (UNDER 5's ONLY)	
Named Allocated GP	

Chatsworth Road Medical Centre

Dr E. Riches
Dr D. Rash
Dr L. Scriven
Dr S. Lewis
Dr A. Galley
Dr S. Rackham
Dr A. Allaway

"Compassionate, Respectful Medical Care"

Storrs Road
Chesterfield
Derbyshire
S40 3PY
Tel: (01246) 568065
Fax: (01246) 567116
www.chatsworthroadmedicalcentre.nhs.uk

New Patient Information

Under 16 Years

We would like to take this opportunity to gather some basic background information about your child's health. This will enable us to assess any treatment they may need in the near future. Any other medical history will be transferred from their medical records when we receive them from their previous GP.

On the basis of this information they may be invited to attend an appointment for a registration medical with one of our Practice Nurse's or GP's.

NAME:	
DOB:	
NHS NUMBER:	
STAFF INITIALS :	***DATE CHECKED :***

DATA SHARING:

The NHS is moving into a new era of information sharing. Locally we have two areas of information sharing which require a decision from you as a patient.

- ***Summary Care Record (SCR)***
- ***Enhanced Data Sharing Model (eDSM)***

Information leaflets relating to the above data sharing areas are included in your "New Patient Information Pack"

PLEASE READ THESE CAREFULLY TO HELP YOU MAKE THE RIGHT DECISION FOR YOU

The Summary Care Record (SCR)

You may recall receiving a letter on the subject of the National Summary Care Record (SCR). Your SCR contains up to date information relating to your medications, any allergies and adverse reactions you have, only. You will always be asked by the clinical staff for your permission to view your child's SCR. (You may have already opted out of this service).

Your child will automatically be set up with a standard version SCR unless you opt out.

I consent to opt my child into the Enhanced SCR ☐

(this will include all the above plus significant medical history, anticipatory care, communication needs, immunisations and end of life care information.)

I have decided to opt out on behalf of my child ☐

Please note: when your child turns 15 1/2 years of age they will be sent a letter regarding their Summary Care Record and it will be their choice to opt in or out of the scheme.

Electronic Prescription Service (EPS / ETP)

On registration we need you to provide us with your preferred pharmacy so we can register you for electronic prescribing as we have now moved to a paperless system. This will mean you collect your medication directly from the pharmacy rather than the practice. Without this information we will not be able to process your regular prescription or future prescriptions.

PLEASE NOTE: If you had a nominated pharmacy at your previous surgery please make sure this is a local pharmacy as your prescriptions will automatically be sent to your current/previous nominated pharmacy which may no longer be convenient for you to collect from.

PARENT/GUARDIAN's CHOSEN PHARMACY……..

(must be completed)

Siblings: (please list below including name, DOB, relationship and address if different to child)

Please give details of anyone else who is living at the same address as child:

(please include name, DOB, relationship and whether they are also registered at Chatsworth Road Medical Centre)

Please give details of anyone else who will be involved in providing care for this child:

(please include name, DOB, relationship and address if different to the child and whether they are registered here)

Does your child suffer from any of the following medical conditions:

Asthma ( )

Diabetes ( )

Epilepsy ( )

Other *(please specify)*

School/Nursery Details - which your Child attends:

Please include Name of School, Address and Telephone Number:

Health Visitors Name:

_____

Our Health Visitors will be contacting you in due course. If however, you have any immediate worries or concerns then please do not hesitate to contact our Health Visitors on **01246 253025,** they are based at Walton.

Previous GP Name:

Address:

Telephone Number:

Accessible Information Standards:

Does your child have any learning disabilities? Yes ( ) No ( )

If yes please give brief details below:

Does your child have a significant hearing impairment? Yes ( ) No ( )

Does your child need to have a hearing loop during consultations? Yes ( ) No ( )

Is your child registered blind? Yes ( ) No ( )

Is your child registered partially sighted? Yes ( ) No ( )

Is there any other way we can make information more accessible to you and your child? For example, large print, Braille, easy read. *If yes please give details below:*

Preferred Contact Method:

POST ☐ **EMAIL** ☐ **SMS** ☐

PLEASE NOTE: if you choose to have your preferred method of contact recorded as Email —your appointment reminders will also be sent via email not SMS.

Does your child take any regular medication?

Including creams/inhalers as well as tablets.

Yes ( ) No ( )

PLEASE NOTE: REGULAR MEDICATION WILL NEED A GP APPOINTMENT BEFORE ANY MEDICATIONS ARE ISSUED.

If yes please give details:

Any allergies to any medication? Yes ( ) No ( )

If yes please give details:

Patients entering the UK from other countries:

If your child has recently entered the country it is imperative that you provide details of any vaccinations your child has received to ensure that our records are correct.

This will enable us to check that your child is up to date with their vaccinations and also ensure your child is called for when they are due any future vaccinations

- (please be aware the UK vaccination schedule differs to other countries).

Address where the child currently resides:

Postcode:

Home Tel:

Sex: **M** ( ) **F** ( )

Is the child in foster care? Yes ( ) No ( )

If yes, please complete foster carer details on the back of the form

Mother's Details: **Next Of Kin:** Yes ( ) No ( )

Name:

DOB:

Address: (if different to child)

Contact Tel No:

Are you also registered at Chatsworth Road Medical Centre? Yes ( ) No ( )

Father's Details: **Next Of Kin:** Yes ( ) No ( )

Name:

DOB:

Address: (if different to child)

Contact Tel No:

Are you also registered at Chatsworth Road Medical Centre? Yes ( ) No ( )

Ethnic Origin: *(Please tick)* **First Language:** _____

White: British ( ) Irish ( ) Other ( )

Mixed: White & Black Caribbean ( ) White & Black African ( ) White & Asian ( ) Other ( )
Asian/Asian British: Indian ( ) Pakistani ( ) Bangladeshi ( ) Other( )
Black/Black British: Caribbean ( ) African ( ) Other ( )
Other Ethnic Groups: Chinese ( ) Any Other ( ) **Not Stated** ( )

Enhanced Data Sharing Model (eDSM)

This is a local information sharing initiative for Healthcare units using the same computer system as your GP Practice (SystmOne). With your permission it allows services such as Midwives, Health Visitors and some hospital departments, to share your **detailed** GP record. It also allows the GP to view what other units record about your child, with your consent.

We have two questions for you.

Are you happy for - Information on our computer system to be seen by Clinicians treating your child in other health care settings who use the same system?

YES ☐ **NO** ☐

Are you happy for - This practice to view the information recorded about your child at other healthcare settings who use the same system?

YES ☐ **NO** ☐

DATA SHARING DECLARATION:

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is able to understand and make an informed decision, then the decision must be theirs.

(PRINT NAME (Child)) _____

DOB: _____

ADDRESS: _____

I have read the information given to me regarding my child's data being shared and understand my decision to opt in / out of the 3 Data Sharing areas outlined in the previous section.

SIGNED (Parent/carer): _____

Relationship to child: _____

DATE: _____