**Welcome to The Old Dairy Health Centre**

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|  ***FOR OFFICE USE*** |
| Checked by: |  |  |
| Date: |  |  |
| Parent(s) Registered |  |
| Catchment Area |  |
| Telephone No. |  |
| Email Details |  |
| Previous GP |  |
| Previous Address |  |
| Ethnicity |  |
| Main Language |  |
| Family History |  |
| Smoking Status |  |
| Alcohol |  |
| Height/Weight |  |
| Patient Consent |  |
| Inform Named GP |  |
| EPS |  |
| HIV Test |  |
| All form complete |  |

# Registration for under 16’s

As it can take several weeks before we receive your medical records please respond to the following questionnaire.

PLEASE WRITE YOUR DETAILS IN CLEAR BLOCK CAPITALS

## Full Name: Date of Birth:

 / / **Address: Post Code:**

## Landline Number: Mobile Number:

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| **CONTACT DETAILS** |
| Mother’s Name: | Tel No.: |
| Father’s Name: | Tel No.: |
| Guardian’s Name (*If applicable*): | Tel No.: |
| Please give details of your Nursery/School: |  |
| Name of Nursery/School: |  |
| Name of Principal/Teacher: |  |
| Address of Nursery/School: |  |
| Tel No. of Nursery/School: |  |
| Is your child currently under the care of Social Services? | Yes ☐ No ☐ |
| If yes, please give name and contact number of Social Worker: Name: Tel: |

**Email Address:**

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PLEASE BRING YOUR **CHILD’S REDBOOK** WITH THIS REGISTRATION FORM**.**

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| **ETHNICITY -** please indicate the ethnic group to which you feel you belong: |
| **White** | **Black** | **Asian** |
| ☐ | British | ☐ | African | ☐ | Bangladeshi |
| ☐ | Irish | ☐ | Caribbean | ☐ | Indian |
| ☐ | Other White Background | ☐ | Black British | ☐ | Pakistani |
| **Mixed Background** | ☐ | Other Black Background | ☐ | Asian British |
| ☐ | White/Black Caribbean | **Other Backgrounds** | ☐ | Chinese |
| ☐ | White/Black African | ☐ | Chinese British | ☐ | Other Asian Background |
| ☐ | White/Asian | ☐ | Vietnamese British | ☐ | Vietnamese |

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| **RELIGION** |  |
| What religion are you? | Religion None ☐ |

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| **LANGUAGE** |
| What is your main spoken language? What language do you prefer to read? |
| Do you have difficulty hearing, or need hearing aids; or need to lip-read what people say? | Yes ☐ No ☐ |
| Do you have difficulty with memory or ability to concentrate, learn or understand? | Yes ☐ No ☐ |
| Can you read English? | Yes ☐ No ☐ |
| Do you have difficulty speaking or using language to communicate or make your needs know? | Yes ☐ No ☐ |
| What is the best way to send you information? Telephone☐ Text relay☐ SMS☐ Letter☐ Email☐ Other: |
| Do you need a format other than standard print? Yes☐ No☐ (If yes, which of the following?) Braille☐ Electronic audio format☐ Easy Read☐ Large Print☐ Other: |
| Do you need the assistance of a Communication Professional? Yes☐ No☐ (If yes, which of the following?)Interpreter☐ Interpreter for Deaf-Blind people☐BSL Interpreter☐ Makaton Interpreter☐ Notetaker☐ Tadoma Interpreter☐ Lipspeaker☐ Sign Language Translator☐ Speech to Text Reporter☐ |
| Do you need an advocate? (Someone to support you communicate or express your point of view) Yes ☐ No ☐ (If yes, please state their name and relationship to you): |

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| **MEDICATION:** Are you on regular medication? If so, please list the names of the medication, dosage and how often you take them, or **attach a list of your medication from your previous surgery**. |
| **Medication Name** | **Dosage/How Often** |
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| The **ELECTRONIC PRESCRIPTION SERVICE (EPS)** is a NHS Service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from. Your prescription will be sent electronically to the pharmacy of your choice. **This means you will not need to come into the surgery to collect your prescription** as it will be prepared and ready for collection at your chosen pharmacy.**PLEASE NOTE THAT THIS DOES NOT APPLY TO PATIENTS WITH A DOSSETT BOX OR PATIENTS WHO ARE ON A CONTROLLED MEDICATION.****For more information about EPS visit** [**www.cfh.nhs.uk/eps**](http://www.cfh.nhs.uk/eps) **or ask one of our receptionists.** |
| Would you like to **subscribe to EPS** or have you previously nominated a pharmacy to send your prescription electronically to? | Yes ☐ | No ☐ |
| If yes please provide the name of your nominated pharmacy and their **POST CODE**: |

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| **MEDICAL HISTORY -** Please give details of the following if applicable: |
|  | **Year(s)** | **Details** |
| **Operations** |  |  |
| **Injuries/Fractures** |  |  |
| **Illnesses** |  |  |
| **Anaesthetics** |  |  |

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| **Do you have a family history of:** (please tick) | **Mother** | **Father** | **Sister** | **Brother** | **Aunt** | **Uncle** | **Maternal** | **Paternal** |
| **Grand Mother** | **Grand Father** | **Grand Mother** | **Grand Father** |
| **Heart disease** |  |  |  |  |  |  |  |  |  |  |
| **Angina** |  |  |  |  |  |  |  |  |  |  |
| **Hypertension** |  |  |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |  |  |
| **Epilepsy** |  |  |  |  |  |  |  |  |  |  |
| **Dementia** |  |  |  |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |  |  |  |
| **Glaucoma** |  |  |  |  |  |  |  |  |  |  |
| **High cholesterol** |  |  |  |  |  |  |  |  |  |  |
| **Stroke/TIA** |  |  |  |  |  |  |  |  |  |  |
| **Thyroid Disease** |  |  |  |  |  |  |  |  |  |  |
| **Mental Health Issues** |  |  |  |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |  |  |  |
| **Lung disease** |  |  |  |  |  |  |  |  |  |  |
| **Learning Disabilities** |  |  |  |  |  |  |  |  |  |  |
| **Cancer (*please state which type)*** |  |  |  |  |  |  |  |  |  |  |
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**ALLERGIES:** are you allergic to any medication, food, animals, etc.? **Yes**☐ *(please state which)* **No**☐

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| **ONGOING MEDICAL PROBLEMS** |
| Stroke☐ | Asthma ☐ | Cancer ☐ | Diabetes ☐ | Epilepsy ☐ | Angina ☐ | Mental Health Issues ☐ |
| Glaucoma ☐ | Heart Disease ☐ | High Blood Pressure☐ | High Cholesterol ☐ | Thyroid Disease ☐ |
| Kidney Disease ☐ | Learning disabilities ☐ | Depression ☐ | Lung Disease ☐ | Dementia ☐ |
| Other (Please give details): |

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| **DIET:** How healthy is your diet? Poor ☐ Average ☐ Good☐ |
| How many portions of fruit/vegetables/salad do you eat per day? |
| Do you eat fried food regularly? | Yes ☐No ☐ |
| Do you drink plenty of water? | Yes ☐ If yes how may glasses/Litres per day? No ☐ |
| Do you drink coffee? | Yes ☐ If yes how many cups per day? No ☐ |
| Do you have a special diet, i.e. low salt, vegetarian, vegan, gluten free?  |

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| **EXERCISE:** Do you take regular exercise? | **Yes** ☐ **No** ☐ |
| **If yes, please state what kind and how often**:  |

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| **WEIGHT:** Kg or st lbs | **HEIGHT:** cm or feet inches |

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| **CHILDREN** |
| Do you have any children? Yes ☐ No ☐ |  |
| If ‘Yes’, how many? How old are they? Do your children live with you? Yes ☐ No ☐Are they registered with our Practice/going to be registered with our Practice? Yes ☐ No ☐If ‘No’ please give name of Practice where registered ………………………………………………….. |

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| **HIV TEST** |
| It is Practice policy to offer all new patients an HIV test. If you decided you would like a test, we will contact you shortly. If you are unsure and would like to speak to someone, we will arrange a telephone consultation with a clinician for you to discuss this further. |
| Do you wish to have an HIV test? | Yes ☐ No ☐ Not sure ☐ |

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| **CARERS** |
| Are you a Carer? (Do you care for an elderly or disabled person? | Yes ☐ No ☐ |
| Are you Cared for?(Are you elderly or disabled and need a friend/relative to help you live your daily life?) | Yes ☐ No ☐ |

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| **PATIENT CONSENT** |
| Do you give consent for the Practice to leave you messages on your **ANSWERPHONE**? | I give consent ☐I **do not** give consent ☐ | Mobile ☐ Landline ☐ Both ☐ |
| Do you give consent for the Practice to contact you via **TEXT/SMS?** | I give consent ☐I **do not** give consent ☐ | Mobile ☐ Landline ☐ Both ☐ |
| Do you give consent for the Practice to contact you via **EMAIL?** | I give consent ☐I **do not** give consent ☐ |  |
| Do you give consent for the Practice to leave messages with a (family member/friend/carer)? | I give consent ☐I **do not** give consent ☐ | Please state their name(s) and relationship to you:  |
| Do you give consent for the Practice to give your prescription to a (family/member/friend/carer)? | I give consent ☐I **do not** give consent ☐ | Please state their name(s) and relationship to you:  |
| **SUMMARY CARE RECORD**Your Summary Care Record (SCR) is an electronic summary of your key health information. It includes any medicines you are taking and any allergies you may have. **Your SCR will help healthcare staff to care for you in an emergency or when your GP Practice is closed.** | I consent to a Summary Care Record ☐ |
| I **do not** consent to a Summary Care Record ☐ |
| **LOCAL CARE RECORD**The Local Care Record enables healthcare professionals to view your medications, previous treatments, test results and any other clinical information electronically between your GP Practice and Guy’s and St Thomas’, King’s College Hospital and South London and Maudsley.Information is only shared when it is needed to make your care and treatment safer, easier and faster and only with those people directly involved in your care. | I consent to a Local Care Record ☐ |
| I **do not** consent to a Local Care Record ☐ |
| **PATIENT PARTICIPATION GROUP**Our PPG consists of members who attend our meetings and those who just wish to be kept informed via email. | Would you like to become a PPG member? Yes ☐ No ☐ |

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| Did someone help you to complete this form? | Yes ☐ No ☐ |

## Patient’s Signature:

(I declare that the information I’ve given above is accurate and truthful)

**Date:** / /

***For Office Use Only:***

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| *Registration Information Entered on Computer* | *Name:* | *Date:* |