CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

If you would like this letter or other information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 01962 852211 or email on whccg.stclementssurgery@nhs.net.

Alternatively, you can also indicate your communication needs using the space below:

My communication needs are:

Braille:
Large Print:
British Sign Language:
Other (please state):

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number ☐☐☐ ☐☐☐ ☐☐☐☐ (if known)

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Please help us trace your previous medical records by providing the following information:

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with [insert name of practice] for Child Health Surveillance

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

☐ I live more than 1 mile in a straight line from the nearest chemist

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.
For more *information please ask at reception for an information leaflet or visit the website* www.uktransplant.org.uk *or call 0300 123 23 23*

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

…… Post code: ……..

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible pelase give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

List of current medication ……

Name of medication	Dosage

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

Ethnicity ……

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state): _____
☐ Decline to state

Next of kin ……

Name: _____ Tel. contact number: _____

Relationship: _____

Data sharing consent choices ……

To maintain continuity of clinical care, we upload and share **certain** medical information so that it is available to other healthcare professionals/organisations (eg Emergency Departments, Community Care Services or agencies involved in your direct care). The information shared is basic medical information; such as your prescriptions, allergies, recent test results and your NHS number. If you do not wish to share this information; please ask for and complete an **OPT-OUT FORM** that is available from the surgery.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, newsletter and the like

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

Electronic Prescription Service

St. Clements Practice uses the Electronic Prescription Service. If you have previously used this service, and wish to continue, you are reminded that it is your responsibility to ensure you nominate a local pharmacist to allow us to dispense your medication.

Signature ……

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ☐ Signature of patient ☐

PLEASE REMEMBER TO LET US KNOW IF YOU HAVE ANY SPECIAL COMMUNICATION NEEDS