KINGSDALE & PERRY PARK MEDICAL CENTRE

Do you need help filling this form out? If so please speak to a member of staff.

TITLE: MR / MRS / MISS /MS / DR / OTHER (Please delete as necessary) **Please complete in BLOCK CAPITALS**

SURNAME .....
.
FIRST NAME: …… MIDDLE NAME (S): ……..

MAIDEN NAME(if applicable)…….....

ADDRESS…….

……

POST CODE…… **OCCUPATION** ……..

DATE OF BIRTH: …….. …….

HOME TEL. NO: …… **MOBILE**: ……..

EMAIL ADDRESS: ……

MAIN LANGUAGE: …….. **INTERPRETER NEEDED**: ……

NATIONALITY: …….. **ETHNIC ORIGIN**……

DO YOU HAVE A CARER? **YES / NO**

IS THE CARER REGISTERED AT THIS SURGERY? **YES / NO**

IF YES, PLEASE GIVE DETAILS:

NAME: .....
ADDRESS:.....
……
TELEPHONE.....

PLEASE CONFIRM THAT YOU AGREE TO YOUR CARER BEING GIVEN PERMISSION TO DISCUSS YOUR MEDICAL MATTERS WITH THE PRACTICE. ***(*Please delete the statement that does not apply).***

***I DO/DO NOT (delete as necessary) GIVE PERMISSION FOR MY CARER NAMED ABOVE TO HAVE PERMISSION TO DEAL WITH MEDICAL MATTERS ON MY BEHALF.**

ARE YOU A CARER FOR ANYONE? **YES / NO**

IS THE PERSON REGISTERED AT THIS PRACTICE? **YES / NO (**IF YES, PLEASE GIVE DETAILS)

NAME: .....
ADDRESS…..
……
TELEPHONE NUMBER: .....

New Patient Questionnaire for Child under 18

Name of Child …… Date of Birth……..

Mothers Name …… Telephone Number ……

Address Details (if different from child)……

Fathers Name …… Telephone number……

Address Details (if different from child)……

Who has parental responsibility? (Please circle one or both if applicable) Mother Father

Someone else (Please state name and relationship to child)……

Next Of Kin (Emergency Contact – if different from above)

Name …….
Address……
Telephone (Home)…… (Work)…… (Mobile)……..

OTHER INFORMATION

If your child is under 1 year of age : Were they premature? Yes / No

Is your child Home schooled? Yes / No

Name of Childs current school ……

Name of previous school (if any) ……

Name of Health Visitor/School Nurse (if Known) ……

Has the child ever been subject of a Child Protection Plan? Yes/ No. If Yes, when? ……

Has your child ever been a "Looked After" child? (i.e. in Foster care or in a children's home) Yes/ No

HOUSING: What type of house does the child live in? (Please circle) Privately owned property / Council Owned Property / Private Rented

House or Flat (If flat, which floor?)……..

Are there any housing problems? e.g. overcrowding, damp etc ……

Please list all the people (children and adults) that share the house with the child and their relationship to the child

Name of Person	**Adult or child** (Please give age if under 18)	**Relationship to child**	**Are they registered with this practice?**
		MOTHER	YES/NO
		FATHER	YES/NO
		BROTHER / SISTER	YES/NO
			YES/NO
			YES/NO

Immunisation History

Please complete the information found in your Childs Red Book or provide us with a photocopy of the Red Book. We will also share this information with Child Health Services to help maintain your child's health record.

Ist Primary Immunsation 8 Weeks	DTap/IPV/Hib/Hep B Men B Rotavirus	Date:
2nd Primary Immunsation 12 Weeks	DTap/IPV/Hib/Hep B Pneumococcal Conjugate(PCV) Rotavirus	Date:
3rd Primary Immunsation 16 Weeks	DTap/IPV/Hib/Hep B Men B	Date:
One Year Old (on or after child first birthday)	Hib/Men C PCV Booster MMR Men B Booster	Date:
Pre School Booster (Three years And four months)	DTap/IPV MMR	Date:

If you have decided NOT to vaccinate your child, please confirm your wishes by signing the declaration below.

No Consent for Immunisation

_____ (child's name), Date of Birth: ___/___/_____

I, _____ (parent's name), parent/guardian of the above child, confirm that, having received information from Kingsdale and Perry Park Surgery, have taken the decision to decline any and all immunisations for the child named above.

I understand that I may amend this decision at any time and can book an appointment to see the Practice Nurse if I wish to discuss this with them.

Signed……

Date ……

For more information, please visit https://www.nhs.uk/conditions/vaccinations

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL CIRCUMSTANCES. IF YOU ANSWER YES PLEASE PROVIDE BRIEF DETAILS:

SMOKING HISTORY

Are you a	Non Smoker		Ex-Smoker		When did you stop smoking?	
	Current Smoker		Would you like help to stop smoking?		How many per day?	

ALCOHOL SCREENING

Please complete the Alcohol Screening table below. Please select the answer which best applies to your drinking in the last year.

1 drink is equal to 1 pint of beer, 1 standard glass of wine or 1 single spirit

QUESTIONS	SCORING SYSTEM					SCORE
	0	1	2	3	4	
How often do you have SIX or more drinks for women and EIGHT for men on one occasion?	Never	Monthly or less	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was normally expected of you because of drinking?	Never	Monthly or less	Monthly	Weekly	Daily or almost daily	
In the last year, has a friend or relative, Doctor or co-worker been concerned about your drinking or suggested you cut down?	Never	Monthly or less	Monthly	Weekly	Daily or almost daily	

PLEASE PROVIDE BRIEF DETAILS:

Do you have any allergies or current conditions? If yes, Please provide brief details:	
Are you currently taking medication? Please provide a copy of your most recent prescription	
The Electronic Prescriptions service is used at this surgery to allow you to collect prescriptions direct from your nominated pharmacy. Please nominate a local Pharmacy for this service.	
Have you had surgery in the last twelve months?	If yes, Please provide brief details:

LONG TERM HEALTH ISSUES

Do you have any long term health issues? Eg Asthma, Diabetes, COPD, Mental Health Learning Disabilities etc. If so please indicate below

Do you have a support worker or carer?

Name……..

Contact No.----------

Do you take any medication for this/these issues? Please indicate below

PLEASE IDENTIFY IF YOU OR ANY FAMILY MEMBERS HAVE SUFFERED WITH ANY OF THE FOLLOWING CONDITIONS. If yes, please provide relationship

Heart Conditions/Disease		
Cancer		
High Blood Pressure		
Death Before the Age of 50		
Asthma		

LATENT TUBERCULOSIS INFECTION SCREENING

We are screening for latent tuberculosis (TB) in patients:

Are you between 16-35 years of age?	
Have you arrived in the country in the last 5 years and never been screened or treated for TB?	
Born in a country with a high risk of TB or spent more than 6 months in a country with a high risk of TB in the past 5 years	

If you answer **YES to ALL three questions** then please can you contact the practice to make an appointment for a free latent TB blood test.

PATIENT ACCESS

To allow us to offer an accessible service to all our patients please provide answers to the following questions. If you answer yes, please provide brief details.

Are you registered disabled?		If yes please provide brief details:	
Are you deaf		Do you require sign language to communicate wi	
Are you hard of hearing?		How is it best to communicate with you?	de on request)
Do you have eye sight problems?		Are you registered blind or require assistance negotiating daily tasks?	
Do you require braille or another method of reading documents?		If yes please provide details:	
Do you have any form of speech Impediment or require assistance with verbal communication?		If yes do you communicate with sign language or require any other assistance to communicate with us?	

You can now book appointments, order repeat prescriptions and even access your GP records online. It's quick, easy and your information is secure. For more information about keeping your healthcare records safe and secure please visit our website: www.nhs.uk/patientonline

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I would like to have access to the Patient Online Services. I confirm that I understand the importance of keeping my details safe and I will inform the practice if I have any concerns or change my mind. (If a patient is under 16 a parent can be added as a proxy user on behalf of the child. Please speak to Reception to find out more)

IMPORTANT NOTICE – YOUR CARE CONNECTED

Your care connected (YCC) is an electronic record sharing system that allows authorized health and care staff to securely view key aspects of the GP record, to provide patients with better and safer care. If you are happy to take part, you do not need to do anything.

If you do not want your information shared, you will need to 'opt-out'. To 'opt-out, please complete the form overleaf and your practice will then process your request to turn off record sharing.

Please see the following website for further information:
www.midlandsyourcareconnected.nhs.uk

When you have handed in your registration form it will usually be 7-10 days before registration is complete**. If you are on any current medication please ensure that you have enough to carry you through this period by speaking to your current surgery as you will need to be seen by a Doctor/Nurse before any medications can be issued.** A welcome letter will be sent to confirm registration at which point you may be invited to attend for an NHS Health Check.

Signature of Patient……

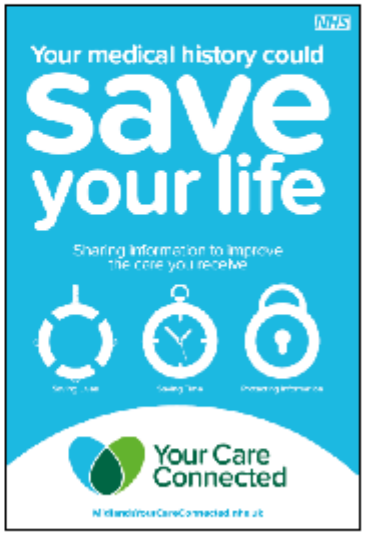
Date…….

Your Care Connected

Website: www.MidlandsYourCareConnected.nhs.uk
Email: infoMidlandsYourCareConnected@nhs.net
Tel: 0333 150 3388 (Leave a voice message)

Your medical history could save your life

Your GP Practice is part of Your Care Connected (YCC), a potentially lifesaving local NHS record sharing service, implemented across Birmingham, Sandwell and Solihull to provide better, safer care. If you need to attend a local hospital, YCC makes it possible for the authorised health and care staff, who are caring for you, to securely access important medical information from your GP record to provide you with better, safer care.



Your Care Connected will only be used to improve the care you receive when you visit one of the local NHS organisations across Birmingham, Sandwell and Solihull as listed on our website:

www.MidlandsYourCareConnected.nhs.uk

Your data will not be: extracted, stored elsewhere, used for research or marketing or sold to any other organisations. **If you opt-out of Your Care Connected, it will also automatically stop your record being shared for any other local record sharing projects** (for example, restricting access to extended services and appointments that are being provided by neighbouring GP practices).

Your information, your choice

If you are happy to take part:

You do not need to do anything. If you visit one of the organisations listed on our website, those treating you will be able to securely access vital information from your record to help improve the care you receive.

If you do not want your information shared:

You will need to 'opt-out' to stop your record from being shared. To 'opt-out', please complete the form below and give this back to your practice. Your practice will then process your request to turn off record sharing.

Opt out form: Only complete if you do not want your information shared

Please complete this form in BLOCK CAPITALS if you do not want your information to be shared. If you wish to opt out on behalf of a child or vulnerable adult, you must request this from their registered GP practice by using this form. However, they may decline your request if they believe it is not in the best interests of the child or vulnerable adult in question.

Title: ..... Name: .....

Date of Birth: ..... (DD/MM/YYYY) Postcode: ..... NHS No: ..... (if known)

I do not want my information to be shared via Your Care Connected. I understand that this may mean important information will not be available to those treating me when making decisions about my treatment in potentially urgent and life-threatening situations. I understand that by opting out of Your Care Connected I will also opt out of any other local sharing initiatives by default. I also understand that if I change my mind I can only opt back in by visiting my GP Practice.

Signed: .....

Date: .....

Please complete and return to your GP practice.

FOR NHS USE ONLY
Date:
Actioned by:

For office use only:

Received by: ……

Date: ……

GP Review: ……

Comments

Date: ……