

New Child Patient Registration Questionnaire

Welcome to Barnabas Medical Centre. Thank you for taking time to complete this questionnaire in **BLOCK CAPITALS**

PERSONAL DETAILS	Have you previously been registered at this practice before? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Name: Mr / Mrs / Miss / Ms /Dr /Other:			
Address:		Postcode:	Date of Birth: / /
			Occupation:
Home Tel:		Mobile:	
Email:		NHS No. (if known):	
Main Language (if not English):		Do you need an interpreter? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Town of Birth:		Country of Birth:	
Preferred method of contact? Telephone Home <input type="checkbox"/> Mobile <input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/>			
Do you consent to us contacting you by SMS text message YES <input type="checkbox"/> NO <input type="checkbox"/>			

ETHNIC ORIGIN	Please tick one box only		
<input type="checkbox"/> White British	<input type="checkbox"/> White Irish	<input type="checkbox"/> White Gypsy or Irish Traveller	<input type="checkbox"/> Other White (Specify).....
<input type="checkbox"/> Arab	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Black African	<input type="checkbox"/> Black Caribbean
<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Mixed White & Asian
<input type="checkbox"/> Mixed White & Black African	<input type="checkbox"/> Mixed White & Black Caribbean	<input type="checkbox"/> Other Asian (Specify).....	<input type="checkbox"/> Other Black (Specify).....
<input type="checkbox"/> Other Mixed (Specify).....	<input type="checkbox"/> Other Ethnic (Specify).....	<input type="checkbox"/> I do not wish to answer this question	

NEXT OF KIN	Name:	Relationship:
	Tel:	

CARERS	Are you a carer for someone else? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Do you have a carer? YES <input type="checkbox"/> NO <input type="checkbox"/> - Carer's Name:		Tel:

MEDICAL HISTORY	Please tick if you have ever suffered or been treated for any of the following:				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Cancer of:
<input type="checkbox"/> COPD	<input type="checkbox"/> Stroke	<input type="checkbox"/> High BP	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Other:

FAMILY HISTORY	Please state if any family member has suffered from any of the conditions listed above:				
Illness/Condition	1.	2.	3.	4.	5.
Family Member					
Aged diagnosed					



Barnabas Medical Centre

MEDICATION	Any allergies to any drugs/medicines? YES <input type="checkbox"/> NO <input type="checkbox"/> Specify:	
Are you taking regular medication? YES <input type="checkbox"/> NO <input type="checkbox"/>		
If Yes, please book a New Patient Registration appointment. Please bring to this appointment all your medication (with packaging) and/or your repeat medication request slip from your previous GP (if applicable)		
Please list any medication you are currently on below.		

VACCINATIONS	Please provide the Personal Child Health Record ("Red Book") or Immunisation records. You can also record any immunisations in the space below		
Date	Immunisation	Date	Immunisation

LIFESTYLE	Height (approx.)?	Weight (approx.)?
Smoking Habits	<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Ex-Smoker, Stopped (year) - Amount when gave up -
		<input type="checkbox"/> Currently Smoke Please state the amount a day and type (cigarette, cigar, pipe etc.)
Only Children over the age of 14 need to complete the above section on smoking		

SCHOOL	Please can you provide the current school attended	
Name of School:		
Address:		Post Code:

RECORD SHARING

An informed patient, in consultation with a Health Care Professional, can choose to permit or restrict access to the information entered into their clinical record at each SystmOne organisation at which they receive care. The patients consent can be changed at any time.

SHARING OUT

Does the patient consent to the sharing of data recorded here with any other organisation that may care for the patient?

YES – share data with other organisations

NO – do not share any data recorded here

SHARING IN

Does the patient consent to viewing of data by this organisation that is recorded at other care services that may care for the patient where the patient agreed to make the data shareable?

CONSENT GIVEN

CONSENT REFUSED

Name

Signature

Date



CHECKLIST

Thank you for completing this form. Please check you have completed all sections where possible.
Please ensure that you bring the following with you to the surgery to complete your registration.

1.	Completed & Signed New Patient Registration Questionnaire (this form)	<input type="checkbox"/>
2.	Completed and Signed GMS1 Form	<input type="checkbox"/>
3.	Photo Proof of ID – e.g. Passport, Photo Driving Licence or Photo ID Card	<input type="checkbox"/>
4.	Proof of Address – This must be in your name and dated within the past 3 months <ul style="list-style-type: none"> Please use one of the following: Bank Statement, Utility Bill (Gas, Water, electric), Council Tax, Tenancy Agreement or Landlord Phone Bill (MOBILE PHONE BILLS ARE NOT ACCEPTED) 	<input type="checkbox"/>
5.	If Possible, your Immunisation Records – usually the Personal Child Health Record (Red Book)	<input type="checkbox"/>
6.	If Possible, your NHS Card – usually shows your previous GP and your NHS number	<input type="checkbox"/>
7.	If relevant, your repeat Medication Request Slip from your previous GP	<input type="checkbox"/>

Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition.

Please request a copy of the Practice Booklet if you have not already received it.

Alternatively you can also find more information at www.barnabasmedicalcentre.co.uk

I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

WE MAINTAIN THE RIGHT TO REMOVE PATIENTS FROM OUR LIST WHO DISPLAY UNACCEPTABLE BEHAVIOUR OR VIOLENCE TOWARDS STAFF OR OTHER PATIENTS

Signature

Date: / / 20__

OFFICIAL USE ONLY	Does the patient need an appointment? YES <input type="checkbox"/> NO <input type="checkbox"/> Staff Initials:			
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving Licence	<input type="checkbox"/> Identity Card	<input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Tenancy Agreement	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other
Was Patient previously registered at this Practice? (Check EMIS for NHS Number)? YES <input type="checkbox"/> NO <input type="checkbox"/>				
Comments:				

How and why we keep information about you and how you can choose who sees it



In order to support your care, NHS healthcare professionals maintain records about you. We take great care to ensure your information is kept securely and used appropriately. Our staff are fully trained to understand their legal and professional obligations to protect your information.

What information do we hold about you?

- Your age, contact details and next of kin
- Details of your appointments, clinic visits etc.
- Records about your health, illness, treatment and care
- Results of investigations, like laboratory tests, x-rays, etc.

Information from other health professionals

When is your information shared?

We will only use or pass on identifiable information about you with health professionals who are treating you to support the direct provision of your care. They will ask your permission to see your information when they see you. We will not disclose your identifiable information to anyone else without your permission unless in exceptional circumstances (i.e. life or death situations), or where the law requires it.

You have the choice to share or not to share

You can ask for all or some of your information not to be shared outside of the practice. If you decide not to share at all this will not affect your entitlement to care. However, it may result in the delivery of your care being less efficient as clinicians will not see your full medical history. If you have any concerns about how your information is shared or held, please contact the Practice Manager.

Access to your health information

You have a right under the Data Protection Act 1998 to access or view information the practice holds about you, and to have it amended or removed should it be inaccurate. We will:

- describe the information we hold about you
- tell you why we are holding that information
- tell you who it might be shared with
- at your request, provide a copy of the information in an intelligible form

If you would like to make a 'subject access request', please contact the practice manager.

Who can see your information with your permission?

In order to provide you with health care services, trained clinicians in the following organisations will be able to see your health care records – but only with your permission.

- Central and North West London NHS Foundation Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- Hounslow and Richmond Community Healthcare Trust
- Imperial College Healthcare NHS Trust
- London North West Healthcare NHS Trust
- NHS Healthcare organisations linking to or using SystemOne systems
- West Middlesex University Hospital NHS Trust

This list will be updated on the website:

www.ealingccg.nhs.uk/patientrecord

Health and Social care teams providing you with integrated care and support may also access your care plans with your permission

How is anonymous information used?

The NHS currently uses your information in an anonymous and safe way to:

- protect the health of the public
- help us anticipate, plan and provide care
- audit and monitor the quality of services provided
- save lives by supporting medical research

If you would like further information about how we use your information, or if you do not want us to use your information in this way, please contact the Practice Manager.

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