This questionnaire is to help us gather information regarding your child/younger person whilst we are waiting for their full medical record to be received from their last Doctor. **PLEASE ENSURE ALL SECTIONS ARE COMPLETE** This will help the transfer run as smoothly as possible.

Please complete in **BLOCK CAPITALS** and tick relevant boxes.

• Please complete a separate form for each child/young person to be registered.

• Please bring in your child’s red book (if Applicable) so we can take a copy of their immunisation record.

• Please bring in the Delegation of Authority Form if you are a carer for this child

• When handing in this form please bring photo ID & proof of address of registering adult.

• In order to provide care and ensure safety we automatically share all children under the age of 16s records with other health professionals. If you have any concerns regarding the sharing of information, please speak to the Practice Manager.

**Child/Young Person’s Personal Details**

All questions marked (\*) are required by the surgery to complete the registration (please complete one registration form for each person)

Registration Details

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title\* |  | | | Pronouns | |  | | |
| Surname\* |  | | | Forename\* | |  | | |
| Date of Birth\* |  | | | | | | | |
| Town of Birth\* |  | | | | | | | |
| Country of Birth\* |  | | | | | | | |
| NHS No (if known) |  | | | | | | | |
| Home Address\* |  | | | | | | | |
| Home tel. number\* |  | | | | | | | |
| Mobile tel. number\* |  | | | | | | | |
| E-mail address\* |  | | | | | | | |
| Gender\* | What is your current gender identity (Please tick one) | | | | | | | |
|  | Male | | | | | | | |
|  | Female | | | | | | | |
|  | Transgender Male/Trans Man/Female-to-Male (FTM) | | | | | | | |
|  | Transgender Female/Trans Woman/Male-to-Female (MTF) | | | | | | | |
|  | Genderqueer, neither exclusively male nor female | | | | | | | |
|  | Additional Gender Category/ (or Other), please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  | Choose not to disclose | | | | | | | |
| What Sex were you assigned at Birth on your original Certificate (Please tick one) \* | | | | | | | | |
|  | Male | | | | | | | |
|  | Female | | | | | | | |
|  | Choose not to disclose | | | | | | | |
| Next of Kin and Emergency Contact | | | | | | | | |
| Name\* |  | | | | | | | |
| Contact Number\* |  | | | | | | | |
|  |  | | |  | | | | |
| Name of Parent(s)/Carer(s) | | | Has legal Responsibility? | | | | Next of kin? | |
| 1. | | | Yes / No | | | | Yes / No | |
| 2. | | | Yes / No | | | | Yes / No | |
| Please list other family members at your address | | | | | | | | |
|  | | Name | | | Registered with us? | | | |
|  | | 1. | | | * Yes | | | * No |
|  | | 2. | | | * Yes | | | * No |
|  | | 3. | | | * Yes | | | * No |
|  | | 4. | | | * Yes | | | * No |
|  | | 5. | | | * Yes | | | * No |
| Name of School/Nursery attended: | | |  | | | | | |
| Is child/Young Person home educated? | | | * Yes | | | | * No | |

**Ethnicity**

What is your ethnic group? Please tick one box that best describes your ethnic group or background from the options below:

|  |
| --- |
| **White**: British Irish Irish Traveller Traveller Gypsy/Romany Polish Any other white background (please write in): |
| **Mixed**: White and Black Caribbean White and Black African White and Asian Any other Mixed background (please write in): |
| **Asian or Asian British:** Indian Pakistani Bangladeshi Any other Asian background (please write in): |
| **Black or Black British:** Caribbean African Somali Nigerian Any other Black background (please write in): |
| **Another ethnic group:** Chinese Filipino Any other ethnic group (please write in): |
| **Not stated:** Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. |

To help us trace your previous medical records please provide the following information

|  |  |
| --- | --- |
| Previous address in the UK\* |  |
| Name of Previous GP Practice\* |  |
| Is this your first NHS registration in England? \* | Y/N  If yes, what date did  you enter the UK? |

**Medical Questionnaire**

Please take the time to complete this document as this information helps us to know more about you as your record will not reach us immediately. As part of the registration process, you may receive a phone call from our Health coach Team for a brief discussion. This is so we can find out a little more about how we can provide appropriate care for your needs.

**Measurements**

|  |  |
| --- | --- |
| Height |  |
| Weight |  |
| Waist measurement |  |

**Personal Medical History**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Q1: Does your child/young person need help with mobility/communication? | | | | * Yes | | * No |
| Does your child/Young Person use: | | | | * Wheelchair * Walking aid * Hearing aid * Makaton Sign language * British Sign Language * Large print * Braille * Interpreter | | |
| Is your child/Young Person currently housebound? | | | | * Yes | | * No |
| If so, please provide details below: | | | | | | |
|  | | | | | | |
| Q2: Please give information about any serious illnesses, operations, or injuries your child/young person has had in the past. *If none, please go to next question* | | | | | | |
| Condition: | Year Diagnosed: | Ongoing: Yes No | | | | |
| **Medication**  If you take any repeat medications, Including Contraception, please provide a copy of your repeat medication slip or complete the table below (if you require more space, please use a separate sheet). | | | | | | |
| |  |  |  | | --- | --- | --- | | Name of Medication | Strength | Dosage | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Q4: Please give details of any allergies or sensitivities your child/Young Person may have to medication/food: | | | | | | |
| Q5: Is your child/Young Person registered with a dentist? | | | * Yes | | * No | |
| To find a dentist visit NHS Choices [www.nhs.uk](http://www.nhs.uk) | | | | | | |

Please ensure you fill out as much information as possible to assist with the completion of the registration

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Q6: Is your child/Young Person or family currently involved with Children’s Services? | | | | * Yes | | | * No | | |
| If yes, please give further details: | | | | | | | | | |
| Name of Social Worker: |  | | | | | | | | |
| Is this child/young person a Looked After Child in the care of the Local Authority? | | | | | * Yes | | | | * No |
| If yes, in what capacity? | | * Permanent | | | | * Temporary | | | |
| Which Local Authority? | | |  | | | | | | |
| Name of Social Worker: | | |  | | | | | | |
| Q7: Is this child/Young Person being looked after by a friend, family member, or neighbour in their home (Private Fostering)? | | | * Yes | | | | | * No | |
| If so, how long have they been looked after by them? | | |  | | | | | | |
| Q8: Is this child/Young Person looking after someone at home? | | | * Yes | | | | | * No | |
| Please let us know if your child/Young Person is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems. | | | | | | | | | |
| If so, do you think they would like additional support as a Young Carer? | | | * Yes | | | | * No | | |

Please Ensure you Read & Sign Page 6

IMPORTANT INFORMATION ABOUT YOUR REGISTRATION WITH RYALLS PARK MEDICAL CENTRE (please read)

**Surgery Processes**

* We do not accept repeat medication/prescription requests by telephone, you can request them yourself via the NHS App or the Patient Access Website or App.
* The NHS App also displays your vaccination record.
* Please see the surgery website for more details and information about the surgery ryallsparkmc.nhs.uk

**How Your Data is Used**

* Your summary care record is an electronic record of your important information about your health. This data is shared between healthcare providers to enable treatment in the case of emergency. For more information or if you would like to opt out, please follow the link below

<https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients>

* GP data collection is how NHS digital extracts anonymised data to support healthcare service through planning and research. For more information or if you would like to opt out, please follow the link below

[National data opt-out - NHS Digital](https://digital.nhs.uk/services/national-data-opt-out)

**By submitting this form to RYALLS PARK MEDICAL CENTRE, you agree:**

|  |
| --- |
| That you may be contacted from time to time, via email and/or SMS with practice news, advice, about your health and/or appointment reminders.  I have read and understood the above questions and am happy for the practice to contact me regarding the information I have submitted on behalf of my Child/Young Person  Signature……………………………………………………………Relationship to Child/Young Person……………………………………………  Printed Name…………………………………………………….. |