# UPPERTHORPE MEDICAL CENTRE

Please complete this form and also a GMS1 form (Purple form) fully and hand into reception.

Please bring proof of address in with the completed forms, and passport if you have not had a doctor in the UK before.

We ask for 1 week in order to get you registered on the system before you can make any appointments.

**For Office use only**

- ○ Form fully completed& GMS1
- ○ Passport seen
- ○ Proof address seen
- ○ Summary Care Record completed

Signed _____

## CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

☐ 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:

## SMS Appointment messaging & other health related communications

If you wish to receive SMS communication from the surgery, please tick the following box ☐

## Do You Have Any Communications Issues Regarding Sight or Hearing

Yes ☐ No ☐

(NOTE – if you indicate yes a brief questionnaire will be posted to you for completion and return)

## Do You Require an Interpreter?

Yes ☐ No ☐ If you aswered yes, which Language? ……

## Parents/Carers Details

| Name | Name |
|---|---|
| Date of birth | Date of Birth |
| Contact Number | Contact Number |

## 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 anyclose 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 |
|---|---|
| | |
| | |
| | |

If you would like to nominate a pharmacy so your prescriptions can be sent electronically please advise us of the name and address of the chemist _____

## 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

What is your spoken Language?

## Are you a Carer…..

Do you care for someone in your family? ☐ Yes ☐No

## Record sharing

Do you consent to the sharing of data recorded here with any other organisations that may care for you?

□**Yes** - share with other organisations.

□**No** – Do not share any data recorded here.

## Summary Care Record

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

**Summary Care Record patient consent form**

Having read the above information regarding your choices, please choose **one** of the options:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

## 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 ☐