Partners in Care

CHILD / Young Person (under 16) Registration

Welcome to Wellington Practice.

Please complete the registration form below.

Once you are on the system you will receive a couple of text to confirm

1. That you are registered

2. Where to find the additional patient information on our website regarding:
    i. Patient Online access
    ii. National data Opt Out
    iii. Privacy Notice

3. Who your usual GP is

4. Any medication review needed (only if relevant)

NHS **Family doctor services registration** GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

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

Your previous address in the UK	
Your previous GP Practice Name and Address and Dr's name	

If you are from abroad:

Your 1st UK address where you first registered with a GP	
Date you first came to live in the UK	
Date you then left the UK	Give all dates
Date you the returned back to the UK	Give all dates

Were you ever registered with a UK Armed Forces GP:

Please indicate if you have ever served in the UK Armed Forces and / or been registered with a Ministry of Defence GP in the UK or overseas. *These forces questions are optional, and your answers will not affect your entitlement to register or receive primary care services form the NHS but may improve access to some NHS priority and service charities services.*

☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Services Child)

Signature of Parent / Guardian of a child/young person applying Patient

Date form completed

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

Signature confirming my consent to join the NHS Organ Donor Register **Date**____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 confirming my consent to join the NHS Blood Donor Register **Date**____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for GMS ☐ Dispensing

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date____/____/____

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to**	

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Country Code:	
3: Name	
4: Given Names	
5: Date of Birth	DD MM YYYY
6: Personal Identification Number	
7: Identification number of the institution	
8: Identification number of the card	
9: Expiry Date	DD MM YYYY

PRC validity period	(a) From: DD MM YYYY	(b) To:	DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Please bring the child's Red Book with you so we can take a copy of their immunisation record.

CONFIDENTIAL MEDICAL REGISTRATION FORM (Children Under 16)

Child's Personal Details:

Please complete all pages in FULL using BLOCK capitals

Child's Surname:

Child's First Names (in full):

Previous Surnames:

Title: ❒ Master ❒ 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[1]:

[1] Note, we use the mobile number for text messages. Text messages will automatically cease when the Child is 11 years old.

Email Address[2]:

[2] Please specify whose above email address this is, e.g. parent, guardian etc.

Name of Parent(s) / Carers	Has Legal / Parental Responsibility?		Next of Kin?	
1.	❒ Yes	❒ No	❒ Yes	❒ No
2.	❒ Yes	❒ No	❒ Yes	❒ No
If not the above, name of person with legal responsibility:				
Contact details of person with legal responsibility				

Does the child have any special communication / mobility needs? ❒ Yes ❒ No

If yes: ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print

❒ Lip Reading ❒ Braille ❒ British Sign Language

❒ Makaton Sign Language ❒ Other: ……..

Is the child currently: ❒ A Refugee ❒ An Asylum Seeker

Is the child a child in care? ❒ Yes ❒ No

Is the child a "Looked After Child"? ❒ Yes ❒ No

If yes to either of the above questions, in what capacity? ❒ Temporary ❒ Permanent

Is the child home educated? ❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Name of child's nursery/school ……

Has the child or family either currently or in the past been known to Children's Services?

❒ Yes ❒ No

Name of Social Worker: ……

Social Worker's Phone No: ……

Required Information:

Is your child looking after someone at home? ❒ Yes ❒ No

If so, who[3]?

[3] Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult's relationship to the child?

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No

Is the child known to services such as Young Carers? ❒ Yes ❒ No

Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

If yes, please provide carer's name:
Carer's relationship to child:
Contact details of carer:

Are Children's services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (**S.66 Children Act 1989**) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the **Children Act 1989, section 105**:*'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.*

Please help us trace the child's previous medical records by providing the following information:

Your previous address in the UK:

Post Code:

Name of previous Doctor while at that address:

Surgery Name and 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 the UK:

If registering a child under 5:

❒ I wish the child above to be registered with Mayfield Medical Centre for Child Health Surveillance

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

For Dispensing Practices only:

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

Patient Declaration for all patients who are not ordinarily resident in the UK:

Please see appendix 1 for patient declaration (last page of form)

Child's Personal Medical History:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No

Family Medical History:

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

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible please 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			

Child's List of Current Medication:

Name of Medication	Dosage

Child's Allergies:

Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Child's Ethnicity:

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

Child's Religion:

Please state religion of child:

Please advise if you feel your child's religion will affect any treatment received: ❒ Yes ❒ No

Child's Language:

Please state child's main spoken language:

Does the child need an interpreter? ❒ Yes ❒ No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

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, the practice newsletter and the like
By text ❒ Yes ❒ No This will be to send you reminders of appointments via text

Signatures:

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 ❒

Name of Person Relationship to Child:

Box for extra details:

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's Details

Please complete in BLOCK CAPITALS and tick ✓as appropriate

❒ Mr ❒ Mrs ❒ Miss ❒ Ms

Surname:

Date of Birth

First Names:

NHS No.

Previous Surname/s:

❒ Male ❒ Female

Town and Country of Birth:

Home Address:	
Postcode:	Telephone No:

Scan and send this page of form to: NHSDigital-EHIC@nhs.net

Summary Care Records

My Choice

Wellington Practice

Forename (s) …….

Surname …….

Date of Birth ……

Signature ……. Date …….

	Office coding	Tick (only ONE) box as applicable
1. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions or sensitivities to medications This summary record will be held on an NHS Central Database and may be used in an emergency when your GP surgery is closed	9Ndm	☐
2. Yes I would like a Summary Care Record created containing my medications, allergies and adverse reactions PLUS additional important information held on my GP record (e.g. diagnoses – Asthma (Lung disease), Kidney disease, Renal disease, Epilepsy, Cancer etc, and end of life requests) AND / OR I will come and see my GP to discuss any additional information I would like added to my Summary care Record as soon as possible	9Ndn	☐
		☐
3. No I do not want a Summary Care Record Please be aware that if you choose not to have a Summary care Record healthcare staff may not have access to important information about you in an emergency but be assured that you will be cared for to the best of their ability	9Nd1	☐
1. Declined to share upload to local shared record (MIG)	93C1	☐

If you do **NOT** want your anonymised data shared with the national database for research and development use, you will need to visit the following website and enter your NHS number plus a few details about yourself.

This then means your data from the surgery record will not be uploaded to the National Data Team for them to use as part of their statistical research purposes.

No personal identifiable data is uploaded if you do not register onto their site to remove yourself from the data upload.

https://www.nhs.uk/your-nhs-data-matters/manage-your-choice/

TEXT SERVICE

For ease of communication we would like to send you (your parents / guardian as appropriate) a text to remind you of your appointment or to say that your results are in and can you call the surgery. We may also use text service to ask you to book a review appointment or a flu vaccination being a number of other things we need to communicate to you. This might for some people not be desirable. So that we can record consent or declining this service please can you tick one of the boxes below.

Your number will **NOT** be used by any other third party – it is only for our use to contact you. However it is **YOUR** responsibility to keep us informed of the correct mobile number to use and for any information sent to you to be in your control. If you choose to share, we cannot be held responsible.

We cannot text where the patient is under16 years of age. If you wish to have a reminder text for your child under the age of 16 you will need to record a parent or responsible guardian mobile number and explicitly state whose number it relates to

I give consent for Wellington Practice to text me relevant information or reminders	☐
I DO NOT give consent for Wellington Practice to text me relevant information or reminders	☐

I give consent for Wellington Practice to text me relevant information or reminders on behalf of my son / daughter as detailed below	
Name of son / daughter ……..……..	☐
Name of son / daughter ……..……..	☐
Name of son / daughter ……..……..	☐
My name for consent is ……..……..	
And my role is that of (circle the one that applies to you)	
Mother / father / legal guardian being ……..……	
And I confirm I have parental responsibility to sign this consent	☐

EMAIL SERVICE

For ease of communication we may need to send you an email for example to provide you with a patient information leaflet or advice about a condition or for possible vaccination / flu vaccination reminders. This might for some people not be desirable. So that we can record consent or declining this service please can you tick one of the boxes below. Your email will **NOT** be used by any other third party – it is only for our use to contact you for something specific. We will not send you marketing information.

My email address is …….

PLEASE BE VERY CLEAR AND ACCURATE AS WE WISH TO AVOID ANY ERRORS

However it is **YOUR** responsibility to keep us informed of the correct email address to use and for any information sent to you to be in your control. If you choose to share, we cannot be held responsible. If you change your email address please do let us know.

We will not email where the patient is under16 years of age unless we have consent to email the parent/guardian. If you wish to have an email communication for your child under the age of 16 you will need to record a parent or responsible guardian email address and explicitly state whose email it relates to

I give consent for Wellington Practice to email me relevant information or reminders	☐
I **DO NOT** give consent for Wellington Practice to email me relevant information or reminders	☐

I give consent for Wellington Practice to email me relevant information or reminders on behalf of my son / daughter as detailed below	
Name of son / daughter ……..……..	☐
Name of son / daughter ……..……..	☐
Name of son / daughter ……..……..	☐
My name for consent is ……..……..	
And my role is that of (circle the one that applies to you)	
Mother / father / legal guardian being ……..……	
And I confirm I have parental responsibility to sign this consent	☐