Southernhay House Surgery

New Child Registration Document

Age 0 - 15

Please choose the correct option:

I am completing this Registration Pack on behalf of my child: (Please circle) **Yes** **No**

I am completing this Registration Pack and I am the patient: (Please circle) **Yes** **No**

(If you are completing the Registration Pack and **you are the patient**, please answer the questions as if they were directed at **you**)

Welcome to Southernhay House Surgery

New Patient Registration Questionnaire

Please ensure that you fill out **all** of the following information on behalf of your child.

Personal Information

- Has your child ever been registered with Southernhay House Surgery?

Yes **No**

Forename(s)	Surname
Previous Surname	Gender: (please circle) Male Female
Current Address: (Please include Post Code) Who else lives in this household? Full Name Relationship to child …….. …… …….. …….. ……... …….. …….. …… …… …….. …… …… …….. …… ……	
Date of Birth:	NHS Number:
Home Tel Number:	Mobile Number:
Place of Birth:	Marital Status:
Occupation:	Religion:
Previous GP and Practice:	Child's Previous Address:
Can we leave messages, (including text messages) regarding your child on the telephone numbers provided?	Home **Yes** **No** Mobile **Yes** **No** (Please circle)

Next of Kin

Name:	Contact Number:
Relationship to Your Child:	

Registering With a NHS GP Practice

Has your child been registered with an NHS GP Practice before? **Yes** **No**

If you have answered **NO** – please complete the boxes below

Has your child just returned to the UK after living abroad? **Yes** **No**
If YES what date did they leave the UK?
What date did they return to the UK?

Was your child born outside of the UK? **Yes** **No**
If YES what date did they first come to the UK?

Ethnicity and Language

The NHS requires all medical records to show a patient's ethnic origin

Please tick your child's ethnic group

White: British or Mixed British		Asian: Pakistani or British Pakistani	
White: Irish		Asian: Bangladeshi or British Bangladeshi	
White: Any other background		Black: Caribbean	
Mixed: White and Black Caribbean		Black: African	
Mixed: White and Black African		Black: Any other background	
Mixed: White and Asian		Chinese	
Mixed: Any other background		Any other ethnic group (please specify)	
Asian: Indian or British Indian			

If your child **needs a translator**, please inform us of the language they require:

_____

Clinical Information

Family Medical History

Do any of the following illnesses run in your child's family? Please tick as appropriate:

Diabetes		Angina	
Asthma		Osteoporosis	
High Blood Pressure		Other Hereditary Disease (please specify type)	
Stroke		Heart Disease	
High Cholesterol		Cancer (please specify type)	
Epilepsy			

Personal Medical History

Does your / has your child ever suffered with any of the following illnesses? Please tick as appropriate:

Diabetes Type I Type II		Angina	
Asthma If YES have they used inhalers in the last 12 months?			
High Blood Pressure		Other Hereditary Disease (please specify)	
Stroke		Heart Disease	
High Cholesterol		Cancer (please specify type)	
Epilepsy		Osteoporosis	

HAVE THEY EVER HAD ANY OTHER ILLNESSES, ACCIDENTS, HOSPITAL ADDMISSIONS, INVESTIGATIONS OR OPERATIONS? (please circle and specify below)

Yes **No**

Date:

Date:

Date :

Is your child a Wheelchair User or unable to climb the stairs? YES/NO (If yes we will put a note on your child's record to ensure all of your appointments are on the ground floor)

Mental Health

Does your child have a history of any of the following mental health issues?

Please circle as appropriate:

Anxiety	Yes No	If YES Date Diagnosed:
Depression	Yes No	If YES Date Diagnosed:
OCD	Yes No	If Yes Date Diagnosed:
Bipolar Disorder	Yes No	If Yes Date Diagnosed:
Personality Disorder	Yes No	If Yes Date Diagnosed:
Psychotic Disorder	Yes No	If Yes Date Diagnosed:
Other Mental Health Issue (please specify)		

FOR FEMALES ONLY

Is your child currently using a form of contraception? Please specify:	
If your child does use contraception when was their last check-up / review with a GP or Nurse?	Date:
If your child has a coil or implant, approximately what date was it fitted?	Date:
If your child has depot injections when was their last one?	Date:
Have your child had a recent smear?	Date:
Have your child had a Hysterectomy?	Date:

Allergies

Does your child have any severe allergies? **No / Yes (please list below)**

1.	3.
2.	4.

Child Protection

Which School does your child attend?

Has your child ever been placed on the Child Protection Register? (Please circle)

Yes **No**

Smoking

Does anyone in the household smoke? (Please circle) **Yes** **No**

Smoking in the presence of children is a health risk. If you, or anyone in your household, would like help and advice to give up smoking please tick box ☐

Immunisation History

A current photocopy of the immunisation history from the Personal Child Health Record (the **"Red Book"**) is the preferred option; we can take a photocopy of this at reception. If this is not available then please list below.

Immunisations	**Date Given**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
1st Pneumococcal	
2nd Pneumococcal	
1st Meningitis C	
2nd Meningitis C	
Hib/ Meningitis C	
1st Measles, Mumps, Rubella (MMR)	
Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio	
Booster Measles, Mumps, Rubella (MMR)	
BCG (Tuberculosis)	
HPV (Cervical Cancer)	
Details of any other immunisations:	

Medication

Is your child taking any regular medication? **Yes** **No**

If YES please specify which medications they take on a regular basis below. It would be very helpful if you had the repeat medication slip from one of their old prescriptions.

Medication	**Dose**	**How many times daily**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Pharmacies

If your child requires repeat prescriptions, and you would like to collect their prescription directly from a pharmacy rather than the surgery, please specify below which pharmacy you would like their prescription sent to. Please note that **ONLY** the pharmacies specified are able to provide this service for our surgery.

Sainsburys	Guildhall		**Day Lewis**	Summer Lane	
	Pinhoe			Beacon Lane	
Lloyds	Heavitree		**Well Pharmacy**		
	Magdalen Road		**St Leonards**		
	Sidwell Street		**Tesco**		
Boots	High Street		**Superdrug**		
	Exe Bridges		**Pinhoe Pharmacy**		

Lifestyle

Smoking Status

Please tick boxes as appropriate

Never Smoked			
Ex-Smoker		Date Stopped?	
Cigarette Smoker		How many per day?	
Roll Own Cigarettes		How many per day?	
Cigar Smoke		How many per day?	
Pipe Smoker		How many grams per day?	

If you answered YES to your child being a smoker would they like help giving up?

Yes No

If you answered YES please call 01884 836024 for further information.

Alcohol Consumption

Each of the above = 1 unit of alcohol

How many units of alcohol does your child drink per week?	Units:

Please now complete the Alcohol Questionnaire

Alcohol FAST Questionnaire

Questions	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Monthly (1) or Less than monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	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	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

If score is 0, 1 or 2 on the first question then continue with the next three questions.
If score is 3 or 4 on the first question – stop here. This indicates FAST positive.

An overall total score of 3 or more (on the first question or all four questions) is FAST positive.

What to do next?

If **FAST positive**, **complete** remaining **AUDIT** questions **over the page**

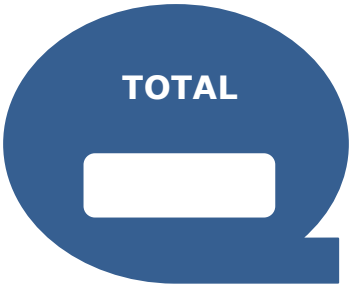
Remaining Alcohol AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	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	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Would you like any help reducing your alcohol consumption? If yes, please book an appointment to see a GP.

TOTAL Score equals
FAST Score (opposite) +
Score of remaining questions



Is your child a Carer?

A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help.

If yes who is your child a carer for?

Name:	
Relationship to your child?	Address: Postcode:
Home Number:	Mobile:
Is the person your child cares for registered at Southernhay House Surgery? **Yes** **No**	

Would you like your child to be included in our carers register? **Yes** **No**

Would you like your child's information passed to SOUTHELP our carers group? **Yes** **No**

Does your child have a Carer?

If YES please provide details below.

Name:	
Relationship to your child?	Address: Postcode:
Home Number:	Mobile:
Is the person who cares for your child registered at Southernhay House Surgery? **Yes** **No**	

Text Messaging and Email Consent

Southernhay House Surgery offers a text messaging and email service for information that is relevant to your on-going healthcare e.g. appointment reminders.

Please **circle** one of the following:

I consent to receiving text messages/emails from Southernhay House Surgery?	**Yes** **No**
My Email Address is:	

I understand that it is my responsibility to inform Southernhay House Surgery should my phone number or email address change or if it has been lost/stolen.

Signed: **Date:**

Southernhay House Surgery

Patient Application for Online Access to My Medical Record

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

*Please note including your email address gives us consent to use it.

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

I wish to access my medical record online and understand and agree with each statement (tick)

I have read and understood the information leaflet provided by the Practice	
I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
If I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me or is inaccurate I will contact the Practice as soon as possible	
If I think that I may come under pressure to give access to someone else unwillingly I will contact the Practice as soon as possible.	

Signature	**Date**

For Practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching □ Vouching with information in record □ Photo ID and proof of residence □	
Authorised by		Date	
Date account created			
Date login details provided			
Level of record access enabled All Prospective Retrospective Detailed coded record Limited parts		Notes / explanation	

Southernhay House Surgery

ACCESSIBLE INFORMATION NEEDS QUESTIONNAIRE

We wish to understand and record any particular communication needs you might have. We will then do our best to meet your needs in all contacts with the Practice.

Name ……

Date of birth ……

Completed by patient / guardian / carer

Date completed …….

1. **Is your communication with others affected by a health problem or disability which has lasted, or is expected to last, at least 12 months?**

   YES / NO

   If YES please complete the rest of the questionnaire

   If NO you don't need to answer any other questions

2. **What health problem or disability do you have?**

   …….

   …….

   What is the best way for us to send you information?

   …….

   …….

3. **Do you need written information in a format other than standard print?**

   …….

   …….

4. **What communication support could we provide for you at appointments?**

   …….

   …….

5. **Can we share this information with other health and social care providers?**

   YES / NO

I confirm that all information given is correct and completed to the best of my ability.

If you have completed the Registration Pack on behalf of a child please PRINT and SIGN here:

Full Name	
Parent/Guardian of	
Signature	

If you have completed the Registration and you are the patient, please PRINT and SIGN here:

Full Name	
Signature	

Please now hand this Registration Pack to a member of the Reception Team