NHS
North West London
Collaboration of
Clinical Commissioning Groups

New Patient Registration Form (Child: under 18 years)

Whilst we are waiting for your child's full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that your child's care is transferred as seamlessly as possible.

- Please complete in BLOCK CAPITALS and tick relevant boxes
- Please complete a separate form for each patient to be registered
- Please bring in your child's red book so we can take a copy of their immunisation record

1	Required Information		
	Your Child's Personal Details		
	Title:		
	Full name:	Date of Birth:	
		NHS No (if known):	
	Gender: □ Female	□ Male	□ Unspecified
	Current Address:	Home tel. number:	
		Mobile tel. number: We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive messages from us: □	
		E-mail address:	

2	Required Information.			
	Looking after a family member/carer.			
	Name of parent(s) / Carer(s)	GP Practice Registered at	Has Legal Parental responsibility?	Next of kin?
	1.		Yes/No/Don't know	Yes/No
	2.		Yes/No/Don't know	Yes/No
	Next of Kin / Name of person(s) with legal parental responsibility:			
	Name:			
	Contact tel. number:			
	Date of Birth:			

	Gender: Male/ Female/ other please state
	Relationship to child:
	Name of school/nursery attended: Is child home educated? Yes/No

	Please list other residents at your home. Are they registered with us?		
	Name:	Relationship to child:	Registered with us Y/N/Unknown

Private Caring Arrangements	
Is your child being looked after by a friend, neighbour in their home? Is this a private fostering arrangement? (Please ask reception if you are unsure) If yes how long have they been living there?	□ Yes □ No
Is someone looking after your child at home? Please let us know if a family member, friend or neighbour helps to look after your child.	□ Yes □ No

Carer's name and address: Carer's Tel. number:	Relationship to you:

Please tick if your child is currently: □ Homeless	□ A refugee	□ An asylum seeker
Is your child currently housebound? If so, please provide details:	□ Yes	□ No
Is the child a 'child looked after' under the care of the local authority? If yes Name of responsible Local Authority: Name of social worker: Name of Foster Carer:	□ Yes If Child 'looked after' Delegated Authority documentation needs to be shared with practice Details shared with Practice □ Yes	□ No
Is your child or family currently involved with Children's Social services or have they ever been known to Children's Social services or the safeguarding team?	□ Yes If yes, please give further details: Name of social worker	□ No

3	Your Child's Background Information. Due to government policy, we are obliged to ask you the following:			
	Your Child's Ethnic Origin: *(please tick one)*			
	□ Black Caribbean/British	□ White (UK)	□ Indian/British Indian	□ Arabic
	□ Black African/British	□ White (Irish)	□ Pakistani/British Pakistani	□ Chinese
	□ Other Black Background	□ White (Other)	□ Bangladeshi/British Bangladeshi	□ Other: *(please state)*
	□ Other Mixed Background: *(please state)*		□ Other Asian Background	□ I do not wish to state my child's ethnic group
	What is your child's main spoken language?			
	Does your child need an interpreter?		□ Yes	□ No
	Does your child need help with mobility/communication? (please tick all that apply)			
	□ Wheelchair	□ Walking aid Please specify:	□ Hearing aid	□ British sign Language (BSL)	□ Makaton sign language
	□ Lip reading	□ Large print	□ Braille	□ Non-verbal/impaired communication	□ Other:

4	Looking after a family member/carer.	
	Is your child looking after someone at home? If so, who: Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs, or substance misuse problems.	□ Yes □ No
	If so, do you think they would like additional support as a young carer?	□ Yes □ No
	Is your child known to services such as young carers?	□ Yes □ No

5 Your Child's Medical Background.

Please give information about any serious illnesses, operations, or injuries your child has had in the past?

Condition	Year Diagnosed	Ongoing Yes / No

Is your child registered with a dentist? To find a dentist visit NHS Choices www.nhs.uk	□ Yes □ No

Please provide details of any medication your child takes (including the contraceptive pill):

Name:	Dosage:	Frequency:

Please give details of any allergies or sensitivities your child may have to medication/food:

Family History

Please let us know if any of the following have affected your child's parents/brothers/sisters:

Please list and specify which family member:

□ Heart disease UNDER the age of 60 Who:	□ Thyroid disorder Who:	□ High blood pressure (Hypertension) Who:	□ Learning difficulties Who:	□ Mental Health problems (e.g. Depression) Who:
□ Heart disease OVER the age of 60 Who:	□ Asthma Who:	□ Stroke (CVA) Who:	□ Epilepsy Who:	□ COPD Who:
□ Cancer Who:	□ Diabetes Who:	□ Renal/Kidney Who:	□ Other:	

6	Immunisation History Which Vaccinations Your Child Had? (Please indicate *Date of Vaccine*)				
Age	Immunisation	Date (DD/MM/YY)	GP Surgery	Private	Abroad
2 months	1st Diphtheria, Tetanus, Pertussis		☐	☐	☐
	1st Polio		☐	☐	☐
	1st HIB, Hep B		☐	☐	☐
	1st Rotavirus		☐	☐	☐
	1st Men B		☐	☐	☐
3 months	2nd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	2nd Polio		☐	☐	☐
	2nd HIB, Hep B		☐	☐	☐
	2nd Rotavirus		☐	☐	☐
	1st Pneumococcal Vaccine		☐	☐	☐
4 months	3rd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	3rd Polio		☐	☐	☐
	3rd HIB, Hep B		☐	☐	☐
	2nd Meningitis B		☐	☐	☐
12 -13 months	Hib/Men C Booster		☐	☐	☐
	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	2nd Pneumococcal Vaccine		☐	☐	☐
	Meningitis B Booster		☐	☐	☐
From 3yrs 4 months	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre- School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐
12-13 yrs	HPV : Cervical Cancer (Girls and Boys)		☐	☐	☐
Teenage Booster	Tetanus,Diphtheria,Polio ACWY Meningitis		☐	☐	☐

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7	Your Child's Online Access.	
	You are now able to book appointments and order repeat prescriptions for your child online.	
	Would you like to register your child for online services?	□ Yes □ No
	If yes, please complete and hand in the online registration form in this pack.	

8	Sharing your child's medical record
	Medical Record Sharing allows your child's complete GP medical record to be made available to authorised healthcare professionals involved in their care. You will always be asked your permission before anybody looks at your child's shared medical record. If you don't want to share your child's GP record locally tick here: ☐
	Summary Care Records contains details of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your child's Summary Care Record. If you don't want your child to have a Summary Care Record tick here: ☐
	The Integrated Care Programme Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as their GP, hospital and community services, to help them provide a full picture of your child's medical needs and the care they are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. I wish to OPT OUT from my child's Personal Confidential Data being shared outside their *GP practice*: ☐

9	Parent/Guardian permission given.	
	Permission given for someone other than a Parent/Guardian to accompany your child to an appointment? E.g. Grandparent, Nanny, childminder	
	Name of person(s):	Parent/Guardian Signature:

10	Your signature.	
	Parent/Guardian Signature:	Date:

Thank you for completing this form
Please see our practice leaflet/website for further information about our team/services.