leamore GP
a family friendly practice


**Leamore GP**
Harden Health Centre
Harden Road
Leamore
WS3 1ET
Tel No: 01922 475015
Website: www.leamoregp.co.uk


# Child Registration Form (<18 yrs)

This form must be completed in full – Incomplete forms will not be processed. If questions on this form are not applicable to you then please state **N/A.**

## Registration requirements

Once you have completed the registration pack please use the tick box below as a guide to confirm evidence of proof of your identity and address to help process your registration successfully**.**

**Select ID attached with this form X;**

| **GMS1** | **Please complete and keep attached with registration pack.** | | | | |
|---|---|---|---|---|---|
| **NHS Identification** | **Tic** | **Evidence of identity** | **Tic** | **Evidence of address** | **Tick** |
| GMS1 Form (Please keep attached with registration pack) | ☐ | Passport | ☐ | Utility Bill (current)/Bank Statement | ☐ |
| | | Driving Licence | ☐ | Council Tax | ☐ |
| | | Birth Certificate | ☐ | State Benefit | ☐ |
| | | | | Tenancy agreement | ☐ |

**Children Under the age of 5yrs please provide Child's RED BOOK or copy of immunisation history.**

Are you on any repeat medication? YES ☐ NO ☐ (X to select)

If Yes, please ensure you have up to four weeks, worth of prescription upon registration.
Please also provide a copy of all your repeat medication that, you have been, prescribed.
Proof can be either the B, side of prescription or letter or medical summary from your GP/consultant stating medication name, dosage, quantity, date of issue.

**Failure to do this will result delay in your registration**

For more Information about the practice please visit our website: www.leamoregp.co.uk

Practice leaflet available please ask at reception

## Childs Details

Mr, Mrs, Miss, Ms, Master: ______Forenames: __________________Surname: ______________________

Middle Name: _________________________________ Any other name; _____________________________

Address: ________________________________________________________________________________

Postcode: ______________________ Date of Birth; ______________________ Gender; F ☐ M ☐

Home Tel: __________________________________

Place of Birth; __________________________ Nationality; ________________________________

## 1 Parent/Guardian

Name; _______________________________________________________________

Address; _____________________________________________________________________________

Postcode: ____________________________ Tel; _______________________

Mobile; ______________________ Work; __________________________________

Email; _____________________________________

Preferred Contact; Home ☐ Mobile ☐ Email ☐

## 2 Parent/Guardian

Name; _______________________________________________________________

Address; _____________________________________________________________________________

PostCode: ____________________________ Tel; _______________________

Mobile; ______________________ Work; __________________________________

Email; _____________________________________ Preferred Contact; __________________________

Preferred Contact; Home ☐ Mobile ☐ Email ☐

## Your Next of Kin Information

Your Next of Kin: ____________________________ Relationship: _____________________________

Address: ______________________________________________________________________________

Postcode: _________________________ Home Tel: ____________________________

Mobile: _______________________________ Work: __________________________________

## Previous GP Details;

Are you currently registered with any other practice? Yes ☐ No ☐

If yes, who? ______________________________

Have you tried to register at another practice locally? ______________________________

Outcome; ______________________________

Why are you moving? ______________________________

If you were previously registered with us why did you leave? ______________________________

Why are you returning? ______________________________

Name of your previous GP; ______________________________

Address of previous GP; ______________________________

Postcode: ______________________________

## Other people living in the household

Name; ______________ Relationship to the child: ______________

Name: ______________ Relationship to the child; ______________

Name: ______________ Relationship to the child; ______________

Name; ______________ Relationship to the child; ______________

Name; ______________ Relationship to the child: ______________

Name; ______________ Relationship to the child; ______________

**Non-School Age**: Yes: ☐ No: ☐

If Yes name of nursery/childminder: ______________________________

**School Age**: Yes: ☐ No: ☐

**Which School**?

Is the school nurse involved in your child's care? Yes: ☐ No: ☐

If Yes, name and number; Name; ______________________________

Tel: ______________________________

## Children's social care

Child in need: ☐

Child protection plan: ☐

Looked after child: ☐

**Is your child under any of the following services?**

CAMHS: ☐

Community Services: ☐

Early help worker including families first: ☐

Family nurse partnership: ☐

Paediatrician: ☐

Social worker: ☐

Other – please state: ____________________

## Special Communication Needs

| Language | If English is not your first language.<br>What is your main spoken language? Please specify ____________________<br>Do you need an Interpreter? Yes ☐ No ☐ |
|---|---|
| Communication | Do you have any communication needs? Yes ☐ No ☐<br>☐ Braille ☐ British Sign Language ☐ Guide Dog<br>☐ Lip reading ☐ Makaton Sign Language ☐ Hearing Aid<br>☐ Large Print |
| Mobility | Wheelchair User: Yes ☐ No ☐ |

## Carer Details

Are you are carer? Yes ☐ No ☐ (If yes) Paid ☐ Unpaid ☐

Do you have a carer; Yes ☐ No ☐ (If yes) Name; ____________________

Relationship to you; ____________________ Tel; ____________________

**Please gain consent before having these details stored on your medical record**

**ETHNIC GROUP DATA COLLECTION - STRICTLY CONFIDENTIAL**

The Health Service needs to know the ethnic group of patients for the purpose of planning. This is to make sure that all sectors of the community have equal access to the services provided. Ethnic group describes how you see yourself, and is a mixture of culture, religion, skin colour, language, the origins of yourself or your family. It is not the same as nationality. The information given will be treated in the strictest confidence. The information is used only by National Health Service Staff and will not be passed on to other agencies or used for any other purposes.

Please select below:

| | | | | |
|---|---|---|---|---|
| ☐ White - British | ☐ White – Irish | ☐ Any other White | ☐ Mixed - White and black Caribbean | ☐ Mixed – White and black African |
| ☐ Mixed White and Asian | ☐ Any other mixed group | ☐ Pakistani | ☐ Bangladeshi | ☐ Any other Asian background |
| ☐ Indian | ☐ Black Caribbean | ☐ Black African | ☐ Any Other Black background | ☐ Chinese |
| Any other Ethnic group! ____________________ Do Not Want to Give Ethnic Group: ____________________ | | | | |
| Are you an Oversea's visitor? Yes ☐ No ☐ (If yes) Date of Entry: | | | | |

## Medical History

Please provide any significant family history of close relatives with medical problems and confirm which relative, e.g Mother, Father, Brother, Sister, Grandparent

Do you suffer with any of the following conditions:

Please provide any significant family history of close relatives with medical problems and confirm which relative e.g Mother, Father, Brother, Sister, Grandparent

| | | | |
|---|---|---|---|
| ☐ Asthma ________ | ☐ COPD _____ | ☐ Epilepsy ____ | ☐ Liver Disease ___ |
| ☐ Blood Pressure ____ | ☐ Depression __ | ☐ Heart Disease ___ | ☐ Kidney Disease___ |
| ☐ Cancer ___________ | ☐ Diabetes ____ | ☐ Heart Failure _____ | ☐ Stroke _________ |

Other: ______________________________________________________________

## Do you Have Any Allergies

Do you have any allergies that you know of or ever had an allergic reaction?

Food:______________________________________________________________

______________________________________________________________

Medication:______________________________________________________________

______________________________________________________________

Other: ______________________________________________________________

______________________________________________________________

## If you are prescribed or taking any medications, please list here.

| Please supply us with a copy of your repeat medication list. Please note a medication review appointment may be required for us to issue these before we add these to your repeat medications at our surgery. Please provide a summary from your previous GP, consultant letter or right side of prescription slip. |
|---|

## Electronic Prescriptions - EPS

We use Electronic Prescribing Service please nominate a pharmacy of your choice or select from the list below.

118 Pharmacy ☐

Broadstone; ☐ Coalpool: ☐ Harden; ☐ Pritchards; ☐

Other: ______________________________________________________________

## Who is the child's main carer?

Name; ______________________________ Relationship to the child; ______________________________

Please sign, date and print name on completion.

| Parent /Guardian Signature | | | |
|---|---|---|---|
| **Signature:** | | **Date:** | |

I confirm that the information provided in this registration is correct and to the best of my knowledge.

| Print Name: | | Date: | |
|---|---|---|---|

**Please use checklist on page 9, attach ID requirements needed for a successful registration.**

**Please complete the following screening questionnaire tool for alcohol use.**

Please select with an X.

| Scoring | 0 points per question | 1 point per question | 2 points per question | 3 points Per question | 4 points Per question |
|---|---|---|---|---|---|
| **1)**How often do you have a drink containing alcohol? | Never: ☐ | Monthly or less: ☐ | 2 – 4 times a month: ☐ | 2 – 3 times a week: ☐ | 4 or more times a week: ☐ |
| **2)**How many drinks do you have containing alcohol on a typical day when you are drinking | 0 – 2 ☐ | 3-4 ☐ | 5 – 6 ☐ | 7 – 9 ☐ | 10 or more ☐ |
| **3)**How often do have four or more drinks on one occasion? | Never: ☐ | Less than monthly: ☐ | Monthly: ☐ | Weekly: ☐ | Daily or almost daily: ☐ |
| **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: ☐ |
| **5)**How often in the last year failed to do what was normally expected of you because of your drinking session. | Never: ☐ | Less than monthly: ☐ | Monthly: ☐ | Weekly: ☐ | Daily or almost daily: ☐ |
| **6)**How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session. | Never: ☐ | Less than monthly: ☐ | Monthly: ☐ | Weekly: ☐ | Daily or almost daily: ☐ |
| **7)**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: ☐ |
| **8)**How often during the last year have you been unable to remember what happened the night before because of your drinking. | Never: ☐ | Less than monthly: ☐ | Monthly: ☐ | Weekly:☐ | Daily or almost daily: ☐ |
| **9)**Have you or someone else have been injured because of your drinking. | No: ☐ | | Yes, but not in the last year: ☐ | | Yes, in the last year: ☐ |
| **10)**Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down. | No: ☐ | | Yes, but not in the last year: ☐ | | Yes, in the last year: ☐ |

Add the score for each column = + + + + +

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Total Score (add column scores) = _______________

Understanding your results:

1-7 = low-risk drinking
8-15 = hazardous drinking
16-19 = harmful drinking
20 + = possible dependence

# <u>Summary Care Record Patient Consent Form</u>

Having read the information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

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

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

**<u>Or</u>**

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

**No – I would <u>not</u> like a Summary Care Record**

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

Name of Patient: ______________________________

Address: ______________________________________________

Postcode: ____________________ Date of Birth: Click or tap to enter a date.

NHS Number (if known): ________________________

**Signature**: ___________________________ **Date**: Click or tap to enter a date.

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ______________________________________

**Please select one:** Parent: ☐ Legal Guardian: ☐ Lasting power of attorney for health and welfare: ☐

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.