**THE EDEN SURGERIES – Broomfields, Hatfield Heath CM22 7EH, 01279 730616. 17 Cannons Lane, Hatfield Broad oak CM22 7HX, 01279 718245**

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**CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)**

**All patients registering at The Eden Surgeries will be allocated a named General Practitioner. Patients are however free to see any doctor of their choice for each consultation although we would encourage you to see the same doctor for the duration of each problem to ensure continuity of care.**

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

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Mstr 🞏 Miss 🞏 Ms 🞏 Male 🞏 Female

Date of Birth (day/month/year) NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

(if known)

Town & country of Birth

Post Code:

Address

Telephone number: Mobile number:

Email address:

**Details of Childs Parent/Main Carer:**

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

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Other ………………….. . 🞏 Male 🞏 Female

Date of Birth (day/month/year)

What is your relationship to the child (i.e. mother/father):

Post Code:

Address

Telephone number: Mobile number:

Does the child have contact with the Mother/Father: YES/NO

**Name and address of Child’s School/Nursery**

Tel No:

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

Your previous address in UK

Post Code:

Name of previous Doctor

while at that address

Post Code:

Address of previous Doctor

**If you are from abroad:**

Your first UK address where

Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

**Dispensing - If you live more than 1 mile in a straight line from the nearest chemist:**

* I live more than 1 mile in a straight line from the nearest chemist and would like to collect my dispensed medications from the Dispensary at Eden Surgeries

**Non - Dispensing - If you live less than 1 mile in a straight line from the nearest chemist:**

* I would like my prescriptions to be sent to Yogi Pharmacy for collection if you’re a Hatfield Broak Oak Surgery Patient

**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 🞏 Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please ask at reception for an information leaflet or visit the website* [*www.uktransplant.org.uk*](http://www.uktransplant.org.uk) *or call 0300 123 23 23*

**Personal Medical History…..**

Type of Birth:

*(eg normal, forceps, Caesarean*

*If under 5)*

Birth Weight: Feeding:

*(If under 5) (Breast or bottlefed*

*If under 5)*

Does your child have any special communication needs? 🞏 Yes 🞏 No

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other

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 any close 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 |
|  |  |  |  |  |  |  |
| Hay fever/eczema | Epilepsy/fits | Stomach/duodenal ulcer | Thyroid disease | Died before the age of 60 | Other |  |
|  |  |  |  |  |  |  |

**Immunisations/Vaccinations**

Please provide details of your childs immunisations with dates if possible (under 5’s). If possible please give your Red Book to Reception to photocopy:

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunisation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Diptheria |  |
| Whooping Cough |  | Rotavirus |  |
| Polio |  | HiB |  |
| MMR |  | Pre school booster MMR |  |
| Meningitis C & Hib booster |  | Pre school booster Dip/Tet/Polio/Whooping cough |  |
| Hepatitas B |  | Any other (inc travel) |  |

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication** | **Dosage** |
|  |  |
|  |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |

**Ethnicity/Ethnic Group Codes**

Please indicate your ethnic origin:

|  |  |  |  |
| --- | --- | --- | --- |
| **White British** XaQEa |  | **White Irish** XaQEb |  |
| **Any other white background** XAJQx |  | **Mixed White & Black Carribean** XaJQy |  |
| **Mixed White & Black african** XaJQz |  | **Mixed White & Asian** XaJRO |  |
| **Any other mixed background – please specify** XaJR1 |  | **Indian (Asian or Asian British)** XaJR2 |  |
| **Pakistani (Asian or British Asian)** XaJR3 |  | **Bangladeshi (Asian or Asian British)** XaJR4 |  |
| **Chinese** XaJR9 |  | **Carribean (Black or Black British)** XaJR6 |  |
| **African (Black or Black British)** XaJR7 |  | **Any other Black background – please specify** XaJR8 |  |
| **Any other Asian background –**  **please specify** ZaJR5 |  | **Any other ethnic group – please specify** XaJRA |  |

**Data sharing consent choices ……**

**vej**

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 Eden Surgeries to contact you by the following:

By text 🞏 Yes 🞏 No This will be to send you reminders of

appointments via text

**Identification ……**

**vej**

For all patients registering at our practice we need to verify your identify by seeing proof of identification. These documents ideally should be:

|  |  |
| --- | --- |
|  | *For office use only* |
| Birth Certificate |  |
| Passport |  |
| Other |  |

If you are unable to provide any of the above or have difficulties obtaining them, please contact Reception who will be able to discuss other options with you.

**Signature ……**

**vej**

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Name:

Signature on behalf of patient 🞏 Signature of patient 🞏

If signing on behalf of patient please state your relationship to the child:

Data Sharing

Please complete the information below with your choices on sharing your data and hand to Reception

**Name: ………………………………………………………………. Date of Birth: …………………………………**

**Address: ……………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**

**Data for research**

I am happy for identifiable data about me to be used for research ☐

I do not wish identifiable data about me to leave the practice ☐

I do not wish data about me to be shared by HSCIC ☐

**Summary care Record**

I am happy for a Summary Care Record to be held for me ☐

I do not wish to have a Summary Care Record ☐

(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

**TPP SystmOne**

I agree to information about me being shared with ☐

Other services using TPP medical systems

I do not agree to information about me being shared with ☐

Other services using TPP medical systems

I agree to the practice seeing information recorded at ☐

Other services using TPP systems.

I do not agree to the practice seeing information recorded ☐

At other services using TPP systems.

Signed: …………………………………………………………………… Date: …………………………..