Emis No.:

Billesdon Surgery

4 Market Place, Billesdon, Leicester, LE7 9AJ
Tel: 0116 2596206, Web: www.billesdonsurgery.co.uk

For children up to 16 years of age

Thank you for applying to join Billesdon Surgery. We would like to gather some information about your child and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give your child the best possible care. **Please supply the child's birth certificate or a form of Identification with the completed form and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION*

*Title: *Surname:	*First names:
*Any previous surname(s) (if applicable):	*Date of Birth: DD / MM / YYYY
* ☐ Male ☐ Female ☐ Intermediate ☐ Unspecified	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth:	*Home address:
*Home telephone No.:	*Postcode:
Work telephone No.:	
*Mobile No. (if you have one):	Email address:

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

*Previous address in the UK (if applicable):	Name of previous doctor:
	Address of previous doctor:
Postcode:	

If your child is from abroad

*First UK address where your child was registered with a GP if your child was previously living abroad:	*If previously a resident in the UK, date of leaving:
	*Date your child first came to live in the UK (if applicable):
Postcode:	

Is the child a dependant of a current serving member of British Armed Forces? ☐ Yes ☐ No

Is the child a Looked after Child? ☐ Yes ☐ No

A child who is being **looked after** by their local authority is known as a **child in care**. They might be living: with foster parents, at home with their parents under the supervision of social services or in residential children's homes.

If you are applying on behalf of a child who is in foster care / residential care / kinship care / or who is not your child

The child is in Foster care ☐ The child is in Residential care ☐ The child is in Kinship care (looked after by relative) ☐

The legal parent or guardian is _____

The above named person can consent for the medical treatment for the child ☐

Other named person can consent for the medical treatment for the child ☐, please specify name_____

If you are registering a child under 5

I wish the child above to be registered with the doctor named for Child Health Surveillance ☐

Additional details about your child

What is your child's ethnic group?				**Main spoken language (E.g. English):**
White	☐ British	☐ Irish	☐ Other White (please specify):	
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):	
Asian	☐ Indian	☐ Pakistani	☐ Chinese	☐ Other Asian (please specify):
Mixed	☐ White + Black Caribbean		☐ White + African	☐ White + Asian ☐ Other mixed:

Next Of Kin / Emergency contact

Are the contacts named below authorised to discuss the child's medical record with us? ☐ Yes ☐ No

1 Name / Relationship to the child / Telephone No. / Address (if different to the child)

2 Name / Relationship to the child / Telephone No. / Address (if different to the child)

Carers Information

A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

Is the child looked after or supported by someone who they couldn't manage without? ☐ Yes ☐ No

If yes, what is their name and contact number?

Do you consent for the carer to be informed about the child's medical care? ☐ Yes ☐ No

Does the child look after or support someone who couldn't manage without them? ☐ Yes ☐ No

If yes, do they look after someone who is a patient of Billesdon Surgery? ☐ Yes ☐ No ☐ Don't know

If yes, what is their name: Are they a ☐ Friend ☐ Relative ☐ Neighbour

Please detail any contact that the child has with other professionals such as health visitors and social workers:

Medical details

In order to continue to receive repeat medications the child will need an appointment with a GP at least one week before the child's next prescription is due.

***Is the child allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

***List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark "none" if the child has no other allergies that you know of) :

Has the child ever had any of the following conditions?

Epilepsy	☐ Yes	Year	**Rheumatoid Arthritis**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Mental Illness (inc Depression)**	☐ Yes	Year
Heart Attack	☐ Yes	Year	**Diabetes (type 1 or type 2)**	☐ Yes	Year
Angina (stable / unstable)	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Transient Ischaemic Attack	☐ Yes	Year	**Osteoporosis / Bone Fractures**	☐ Yes	Year
Cancer	☐ Yes	Year	**Peripheral Vascular Disease**	☐ Yes	Year

List any serious illnesses / operations / accidents / disabilities and the year they took place:

Does your child have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your child's needs:

Does the child have Family History of any of the following?

High Blood Pressure	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who
Stroke / CVA	☐ Yes	Who
Asthma	☐ Yes	Who
Diabetes	☐ Yes	Who

DVT / Pulmonary Embolism	☐ Yes	Who
Breast Cancer	☐ Yes	Who
Any Cancer Specify type:	☐ Yes	Who
Thyroid disorder	☐ Yes	Who
Epilepsy	☐ Yes	Who
Osteoporosis	☐ Yes	Who
Other (please specify)		Who

Please tell us about your child's smoking habits

*Does your child smoke? ☐ Yes ☐ No
If Yes, what do they primarily smoke:
Cigarettes / Cigar / Pipe / Vape **(please circle)**
How many do they smoke a day?

Would you like advice on quitting? ☐ Yes ☐ No

Is your child an ex-smoker ☐ Yes ☐ No
When did they quit?

How many did they used to smoke a day?

Does your child exercise regularly? ☐ Yes ☐ No If yes, what exercise do they take and how often:

Communication Preferences

We may want to contact you by email, send appointment reminders to your mobile and leave messages on your answering machine, if you have one. **Tick these boxes if you <u>do not</u> wish to be contacted in this way:**
☐ **Email** ☐ **SMS** ☐ **Answering machine** ☐ **Letter Post**

Data Sharing

Summary Care Record (SCR)
As you are registering your child with this practice, we would like to recommend that you take advantage of the Summary Care Record (SCR). The Core SCR includes important information about your child's health: Medicines your child are taking, allergies they suffer from and any bad reactions to medicines.

You can also choose to have additional information included in your child's SCR, which can improve the care your child receives. This information includes: Your child's illnesses and health problems, operations and vaccinations they have had in the past, how they would like to be treated – such as where you would prefer your child to receive care; what support your child might need and who should be contacted for more information about them.

Your child may need to be treated by health and care professionals outside of the practice who do not know your child's medical history. Having the additional information SCR can help the staff involved in your child's care access information more quickly, allowing them to make informed decisions about their healthcare. More information can be found by visiting www.nhscarerecords.nhs.uk

Tick this box if you wish to <u>opt-in</u> your child to the **Core SCR** ☐

Tick this box if you wish to <u>opt-in</u> your child to the **Core and Additional SCR** ☐

Tick this box if you wish to <u>opt-out</u> your child from the **SCR** ☐

Medical Interoperability Gateway (MIG)
Whilst the SCR mentioned above shares a very small portion of your child's medical record across the whole NHS, the MIG shares a much broader view of their records but only with local NHS providers – and only when you give explicit consent at the point of care. For more information please visit https://healthcaregateway.co.uk/

The Accessible Information Standard (AIS)
Please use this space to tell us about any specific communication needs your child has. i.e. needing information in large print or deafblind telephone contact. For further information please visit **https://www.england.nhs.uk/ourwork/accessibleinfo/**

Donor Registration Choices

NHS Organ Donor Registration

"I want to register my child's details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after their death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

Online Patient Access

Once your application for your child to join our practice has been accepted you'll be able to order your child's repeat medications and book appointments. This service is known as **Patient Access**. To register visit **www.billesdonsurgery.co.uk** or ask reception for an **application form**. You need to bring the completed form to reception then you'll be emailed a registration letter within **seven working days** so you can create the online account. Please note ***you must have an email address to use this service and given consent to receive emails from Billesdon Surgery***. Full terms and conditions are available on the application form.

Once your child is registered…

Electronic Prescription Service (EPS)

… you will be able to nominate a pharmacy to collect your child's prescriptions from. EPS enables prescribers, such as GP's and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service please talk to your pharmacist of choice.

Please record any additional information about you that you think is important for us to know on a separate sheet of paper and attached to this registration form.

***Signed (on behalf of the child):**	***Date** DD / MM / YYYY

SUPPLEMENTARY QUESTIONS

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 / YYYY
***Print name:**		***Relationship to patient:**	
***On behalf of:**			

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.

FOR OFFICE USE ONLY

Date:_____ Staff Initials:_____

BIRTH CERT. SEEN ☐ ***Or* ADDRESS ID SEEN** ☐ **TYPE:** _____
Or RED BOOK SEEN ☐