



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 you 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 you 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:
*Any previous surname(s) (if applicable):	
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	
*Town and country of birth:	
*Home telephone No.:	
*Mobile No. (if you have one):	

*First names:
*Date of Birth:
*NHS No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Home address & Postcode:
*Previous address & Postcode (if applicable):
Email address:

*Previous GP Details (name and address) (if applicable):
*School that child is registered with:

*Is the child a looked after child? <input type="checkbox"/> Yes <input type="checkbox"/> No
A <b>child</b> who is being <b>looked after</b> by their local authority is known as a <b>child in care</b> . They might be living: with foster parents, at home with their parents under the supervision of social services or in <b>residential children's homes</b> .

### If the child is in foster care/residential care/kinship care

The child is in Foster care <input type="checkbox"/>	The child is in Residential care <input type="checkbox"/>	The child is in Kinship care (looked after by relative) <input type="checkbox"/>
The legal parent or guardian is _____		
The above named person can consent for the medical treatment for the child <input type="checkbox"/>		
Other named person can consent for the medical treatment for the child <input type="checkbox"/> , please specify name _____		

### Additional details about the child

I would describe the child's ethnic group as...	Child's main spoken language (E.g. English):
<b>White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other White (please specify):	
<b>Black</b> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black (please specify):	
<b>Asian</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian (please specify):	
<b>Mixed</b> <input type="checkbox"/> White + Black Caribbean <input type="checkbox"/> White + African <input type="checkbox"/> White + Asian <input type="checkbox"/> Other mixed:	

Is the child a dependant of a current serving member of British Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**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 your 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?**

<b>Epilepsy</b>	<input type="checkbox"/> Yes	Year
<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Year
<b>Heart Attack / Angina</b>	<input type="checkbox"/> Yes	Year
<b>Stroke / Mini-Stroke (TIA)</b>	<input type="checkbox"/> Yes	Year
<b>Cancer</b>	<input type="checkbox"/> Yes	Year
<b>Rheumatoid Arthritis</b>	<input type="checkbox"/> Yes	Year

<b>Mental Illness (inc Depression)</b>	<input type="checkbox"/> Yes	Year
<b>Diabetes (type 1 or type 2)</b>	<input type="checkbox"/> Yes	Year
<b>Asthma</b>	<input type="checkbox"/> Yes	Year
<b>COPD (or Emphysema)</b>	<input type="checkbox"/> Yes	Year
<b>Osteoporosis / Bone Fractures</b>	<input type="checkbox"/> Yes	Year
<b>Peripheral Vascular Disease</b>	<input type="checkbox"/> Yes	Year

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

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

<b>High Blood Pressure</b>	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
<b>Ischaemic Heart Disease</b> Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
<b>Raised Cholesterol</b>	<input type="checkbox"/> Yes	Who
<b>Stroke / CVA</b>	<input type="checkbox"/> Yes	Who
<b>Asthma</b>	<input type="checkbox"/> Yes	Who

<b>DVT / Pulmonary Embolism</b>	<input type="checkbox"/> Yes	Who
<b>Breast Cancer</b>	<input type="checkbox"/> Yes	Who
<b>Any Cancer</b> Specify type:	<input type="checkbox"/> Yes	Who
<b>Thyroid disorder</b>	<input type="checkbox"/> Yes	Who
<b>Epilepsy</b>	<input type="checkbox"/> Yes	Who
<b>Osteoporosis</b>	<input type="checkbox"/> Yes	Who

**Please tell us about the child's smoking habits**

Does the child smoke?  Yes  No  
 If Yes, what do they primarily smoke:  
 Cigarettes / Cigar / Pipe (please circle)  
 How many do they smoke a day?  
 Would you like advice on quitting?  Yes  No

Is the 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 you take and how often:

**Data Sharing**

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 do not wish to be contacted in this way:** Email  SMS  Answering machine

**Summary Care Record (SCR)**

Your SCR is an electronic summary of key medical information taken from your medical record. If you need healthcare away from your usual doctor's surgery, your enhanced SCR will provide those looking after you with key information to help them give you better and quicker care. **For more information visit: <http://systems.digital.nhs.uk/scr>**

Tick this box if you wish your child to have an enhanced SCR with core and additional information (recommended)

Tick this box if wish to **opt-out** your child from the SCR

**Medical Interoperability Gateway (MIG)**

Whilst the SCR shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care. **For more information visit: <http://www.healthcaregateway.co.uk/products>**

Tick this box if you wish to **opt-out** of the MIG

**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 my 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](http://www.uktransplant.org.uk) or call 0300 123 23 23**

**The Accessible Information Standard (AIS)**

Please use this space to tell us about any specific communication needs your child may have. i.e. needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

**In accordance with the Data Protection Act, the practice needs consent if you are happy for a 3<sup>rd</sup> party to collect prescriptions, test results and other medical information on your child's behalf. Please complete this section if you would like to register a 3<sup>rd</sup> party.**

I give consent for \_\_\_\_\_ to collect prescriptions on my child's behalf (Please note that we are unable to hand out prescriptions to anyone under the age of 15)

I give consent for \_\_\_\_\_ to obtain test results / medical information / appointment information on my child's behalf (Delete as appropriate)

**IT IS YOUR RESPONSIBILITY TO ADVISE US OF ANY CHANGES TO THESE INSTRUCTIONS:**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

#### **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 **Online Patient Access**. To register for this service either visit our website [www.billesdonsurgery.co.uk](http://www.billesdonsurgery.co.uk) or ask reception for an **application form**. You'll be emailed a PIN letter within **seven working days**. You'll use this PIN letter to create your child's online account. Please note **you must have an email address to use this service and consent to receiving emails from Billesdon Surgery**. Patient Access for children under 16 is known as **Proxy Access**, when your child turns 16 their account will automatically close and they will need to register themselves for a new account with their own email address. Full terms and conditions are available on the application form.

#### **Once your child is registered...**

If there are any problems with your child's registration we'll contact you to clarify any issues, but once your child's details have been entered into our computerized records...

#### New Patient Health-check

...Your child will be eligible for a new patient health-check with a Practice Nurse/Health Care Assistant. Contact reception if you should like to take this up.

#### 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 your child that you think is important for us to know**

**\* SIGNED (on behalf of the child):**

**\*Date**        /        /        /

#### **FOR OFFICE USE ONLY**

BIRTH CERT. SEEN         Or ADDRESS ID SEEN         TYPE: \_\_\_\_\_  
Or RED BOOK SEEN



Leicester City Clinical Commissioning Group  
 West Leicestershire Clinical Commissioning Group  
 East Leicestershire and Rutland Clinical Commissioning Group

# NHS Enhanced Summary Care Record with additional information

If you are registered with a GP practice in England you will have a core Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

You can also choose to have additional information included in your SCR, which can enhance the care you receive. This information includes:

- Your illnesses and health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated – such as where you would prefer to receive care
- What support you might need
- Who should be contacted for more information about you

Healthcare leads across LLR recommend that all patients sign up. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an enhanced SCR can help the staff involved in your care access information more quickly, enabling them to make better and safer decisions about your treatment.

### What to do next

If you would like your SCR to be enhanced with additional information (or the SCR of someone you are a carer for), then please complete this form, to be returned to your GP surgery.

Name of patient: .....

Date of birth: ..... Patient's postcode: .....

Surgery name and location: .....

NHS number (if known): .....

Signature: ..... Date: .....

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

Name: .....

Capacity:  
Please circle one

Parent	Legal Guardian	Lasting power of attorney for health and welfare
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If you require any more information, please visit <https://digital.nhs.uk/summary-care-records> or speak to your GP Practice.