Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……

CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number (if known) ☐☐☐ ☐☐☐ ☐☐☐☐

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

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

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with [insert name of practice] for Child Health Surveillance

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

☐ I live more than 1 mile in a straight line from the nearest chemist

NHS Organ Donor registration:

Practices will no longer be able to record this information and patients should visit the organ donation website to make their choices. If you would like to speak to somebody about your choices, please call the NHS dedicated line: **0300 123 23 23.**

The Organ Donation opt out system in England came into effect on 20 May 2020. This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups below:

- Those under the age of 18
- People who lack the mental capacity to understand the new arrangements and take the necessary action
- Visitors to England, and those not living here voluntarily
- People who have lived in England for less than 12 months before their death

You still have a choice whether or not you wish to become a donor. Get the facts about organ donation to help you decide.

More information can also be found at https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/

NHS Blood Donor registration:

You can give blood if you:

- are fit and healthy
- weigh between 7 stone 12 lbs and 25 stone, or 50kg and 158kg
- are aged between 17 and 66 (or 70 if you have given blood before)
- are over 70 and have given a full blood donation in the last two years

For information, please see *https://www.blood.co.uk* or call 0300 123 23 23

Patient Declaration for all patients who are not ordinarily resident in the UK

Please see appendix 1 for patient declaration (last page of form)

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

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

Immunisations ……

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

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

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 ……

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state): _____
☐ Decline to state

Next of kin ……

Name: _____ Tel. contact number: _____

Relationship: _____

Data sharing consent choices ……

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 [insert name of practice] to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, newsletter and the like

By text ☐ Yes ☐ No This will be to send you reminders of appointments via text

Signature ……

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

Signed: _____ Date: _____

Signature on behalf of patient ☐ Signature of patient ☐

Updated 26/09/17

Appendix 1

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth | | | | | | | | |

First names

NHS No. | | | | | | | | | | |

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

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 YY
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:
	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	
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.	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.

Scan and send this page of form to: NHSDigital-EHIC@nhs.net

Updated 02.06.20

The Old Fire Station Surgery, 68a Portsmouth Road, Woolston, Southampton SO19 9AN

Dr A M Purcell Dr K Malone Dr Lockwood Dr Blunden Dr Harding Dr Ku

In order for us to provide you with the best medical care, please complete this questionnaire. Please circle if there is a particular Doctor you would like to be registered with.

Personal Details

Name	
Sex	Male / Female
Date of Birth	
Marital Status	
Place of Birth	
Ethnic Origin	
Religion	
Have you been registered at this surgery before?	YES / NO
Telephone: Home	
Mobile	
Work	
Email Address	
Would you consent to being contacted by the surgery via	E-mail YES / NO
	Text YES / NO
Occupation or Name and Address of School	
Next of Kin (*Please supply name, address, telephone number and relationship*)	
Are you a carer? If yes, who do you care for and why? What care do you provide?	
Do you have a carer?	
What is your first language?	
Do you require an interpreter?	

Family History

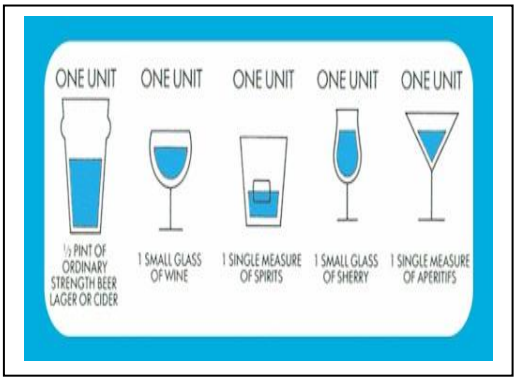
Do any members of your immediate family have any of the following? (i.e. mother, father, brothers, sisters, grandparents)	**Illnesses**	**YES / NO**	**Family member, age diagnosed and details**
	Heart disease		
	Stroke		
	Diabetes		
	Asthma		
	Cancer		
	High Blood pressure		
	Glaucoma		

Medical Information

List any illness you have had in the past or are taking regular medication for at present.	
Are you on any regular medication?	
Do you currently have your prescription sent straight to a pharmacy for dispensing?	YES / NO
If this request is from your old surgery do we need to remove the pharmacy from your records?	YES / NO
Which local pharmacy do you want to have your script sent to?	
Are you currently under the care of any specialist? (If 'YES', please give name, speciality and hospital).	
Are you allergic to any drugs or medicines? If 'YES', please list drug and the reaction it caused.	

ALCOHOL CONSUMPTION

		Please tick
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	
How many units of alcohol do you drink on a typical day when you are drinking?	N/A	
	1 or 2	
	3 or 4	
	5 or 6	
	7 or 8	
	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	N/A	
	Never	
	Less than monthly	
	Monthly	
	Weekly	
	Daily or almost daily	
If we require more information regarding your alcohol consumption would it be okay for us to send you a further questionnaire?	Yes	
	No	



Do you smoke?	YES / NO	**If you smoke and would like some help in giving up, please contact "Healthy Living Southampton" on 0300 1233791, or make an appointment with your GP.**
If 'YES', how many do you smoke a day	…….. per day	
Are you an ex-smoker?	YES /NO	
When did you stop smoking?		

Female only

What form of contraception do you use?	
When did you have your last cervical smear?	

◯

Please tick this box if you would like to be involved in our Patient Representative Group. This involves receiving 2-3 e-mailed surveys yearly and is a great opportunity to give your views and opinions to the surgery.

If you are already registered at another local surgery and want to register here without changing address please give an explanation why.