THE WILSON PRACTICE

New Patient Registration Form

CHILD UNDER 16

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

Please also bring the child's Red Book with you so we can take a copy of their immunisation record.

If your child is UNDER 5 years old please fill in the child transfer/change of address form attached to this registration pack

Child's Surname:

Child's First Names (in full):

Previous Surnames:

Title: ❒ Master ❒ Miss ❒ Ms ❒ Mx

Gender: ❒ Male ❒ Female

Date of Birth (d/m/y) __ __ . __ __ . 2 0 __ __

Town & Country of Birth:

Address:

Post Code:

Telephone Number: Mobile:

Note: Children under 16 will automatically be opted out of information text messages and email communication.

Email Address:

Please specify whose above email address this is, e.g. parent, guardian etc.

Name of Parent(s) / Carers	Has Legal / Parental Responsibility?		Next of Kin?	
1.	❒Yes	❒ No	❒Yes	❒ No
2.	❒Yes	❒ No	❒Yes	❒ No
If not the above, name of person with legal responsibility:				
Contact details of person with legal responsibility:				

Does the child have any special communication / mobility needs? ❒ Yes ❒ No

If yes: ❒ Wheelchair ❒ Walking Aid ❒ Hearing Aid ❒ Large Print
❒ Lip Reading ❒ Braille ❒ British Sign Language
❒ Makaton Sign Language ❒ Other: ……………………………………...

Is the child currently: ❒ A Refugee ❒ An Asylum Seeker

Is the child a child in care? ❒ Yes ❒ No

Is the child a "Looked After Child"? ❒ Yes ❒ No

If yes to either of the above questions, in what capacity? ❒ Temporary ❒ Permanent

Is the child home educated? ❒ Yes ❒ No

Name of Social Worker: ……..………………………………………………………………………………..

Social Worker's Phone No: …………………..………………………………………………………………...

Name of child's nursery/school ……………..…………………………………………………………………

Has the child or family either currently or in the past been known to Children's Services?

❒ Yes ❒ No

Name of Social Worker: ………………………………………………………………………………………

Social Worker's Phone No: ………..…………….…..………………………………………………………..

Required Information:

Is your child looking after someone at home? ❒ Yes ❒ No

If so, who?

Please tell us if the child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems

What is the adult's relationship to the child?

Do you think the child would like additional support as a young carer? ❒ Yes ❒ No
Is the child known to services such as Young Carers? ❒ Yes ❒ No

---

Is the child being privately fostered (*see definition below*)? ❒ Yes ❒ No

If yes, please provide carer's name:
Carer's relationship to child:
Contact details of carer:

Are Children's services aware? ❒ Yes ❒ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (S.66 Children Act 1989) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, **but cannot be a relative** as defined under the Children Act 1989, section 105:*'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.*

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

Previous address in the UK:	Post Code:
Name of Previous Doctor while at that address:	
Surgery Name and 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 the UK:	

Child's Personal Medical History:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Child's List of Current Medication:

Name of Medication	Dosage

Child's Immunisations:

Please provide details of your child's immunisations with dates if possible (under 5's). If possible please 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			

Family Medical History:

Have any <u>close relatives</u> (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

Child's Allergies:

Please list any allergies the child has to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Child's Ethnicity:

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

Child's Religion:

Please state religion of child:

Please advise if you feel your child's religion will affect any treatment received: ❒ Yes ❒ No

Child's Language:

Please state child's main spoken language:

Does the child need an interpreter? ❒ Yes ❒ No

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.
For more detailed information and how you can set your preferences please visit our website.

Signatures:

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 ❒

Name of Person: ____________________ Relationship to Child: __________

For more information about the services we offer please see our website: www.wilsonpractice.co.uk

Hampshire Community Health Care

CHILD TRANSFER / CHANGE OF ADDRESS FORM
FOR CHILDREN UNDER 5

DATE: ______________________

TO:
Child Health Information Services
Maternal & Child Health Division
1st Floor Thomas Lewis House
Thomas Lewis Way
Southampton,Hants
SO14 0JU

Tel: 02380 294424/294403

FROM:
Alton Child Health Team
1st Floor, Alton Health Centre
Anstey Road
Alton,Hants
GU34 2QX

Tel: 01429 88336
Fax: 01420 543 450
E-mail: hamp- pct.AltonHVTeams@nhs.net

Mother's First Name: ______________________ Mother's Last Name: ________________________

Mother's DOB: _____._____.____________

Have the notes been handed over to the new HV? YES / NO

Have the notes passed via Safeguarding? YES / NO

(BLOCK CAPITALS PLEASE)

Name of Child: ______________________ Surname of Child: _________________________

NHS Number: _______________________________ DOB: _____._____.__________

Sex: M / F

Previous Address Postcode	New Address Postcode
	Tel No
Previous GP	New GP
Previous GP Practice	New GP Practice
Previous HV	New HV
Previous Treatment Centre	New Treatment Centre

IMMUNISATION STATUS

Course	Date Given
1st Primary, Polio, Hib	
2nd Primary, Polio, Hib	
3rd Primary, Polio, Hib	
1st Meningitis ‘C’	
2nd Meningitis ‘C’	
3rd Meningitis ‘C’	
1st Pneumococcal (PCV)	
2nd Pneumococcal (PCV)	
Pneumococcal Booster (PCV)	
Hib/MenC Booster	
MMR	
MMR 2	
Dip/Tetanus/Polio (pre-school)	
Dip/Tetanus/Polio (pre-school)/Hib	
BCG	
1st Hepatitis B	
2nd Hepatitis B	
3rd Hepatitis B	
4th Hepatitis B	
Other (Please state course and dose)	

NEWBORN BLOOD SPOT SCREENING (UNDER 1 YEAR OLDs ONLY)
Please state result clearly and provide further information if results no available.

Date of Test		
	Result	**Country of Test**
PKU (Phenylketonuria)		
CHT (Congenital Hypothyroidism)		
CF (Cystic Fibrosis)		
MCADD		
SCD (Sickle Cell)		

If results not available please fill in below

Original result missing YES / NO

Original test declined YES / NO

Referral made for re-test or first test YES / NO

Referred to: ______________________________

Date of Appt: ______________________________