

**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 surnames \_\_\_\_\_  
 Male  Female Town and country of birth \_\_\_\_\_  
 Home address \_\_\_\_\_  
 \_\_\_\_\_  
 Postcode \_\_\_\_\_ Telephone number \_\_\_\_\_

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

Your previous address in UK \_\_\_\_\_ Name of previous GP practice while at that address \_\_\_\_\_  
 \_\_\_\_\_ Address of previous GP practice \_\_\_\_\_  
 \_\_\_\_\_

**If you are from abroad**

Your first UK address where registered with a GP \_\_\_\_\_  
 \_\_\_\_\_  
 If previously resident in UK, date of leaving \_\_\_\_\_ Date you first came to live in UK \_\_\_\_\_

**Were you ever registered with an Armed Forces GP**

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas:  Regular  Reservist  Veteran  Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting: \_\_\_\_\_  
 \_\_\_\_\_  
 Postcode \_\_\_\_\_  
 Service or Personnel number: \_\_\_\_\_ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

**If you need your doctor to dispense medicines and appliances\***

I live more than 1.6km in a straight line from the nearest chemist  
 I would have serious difficulty in getting them from a chemist  
 \*Not all doctors are authorised to dispense medicines  
 Signature of Patient  Signature on behalf of patient  
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**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  
 Signature confirming my consent to join the NHS Organ Donor Register \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) or call 0300 123 23 23 to register your decision.

**NHS Blood Donor registration**  
 I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years   
 Signature confirming my consent to join the NHS Blood Donor Register \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 My preferred address for donation is: (only if different from above, e.g. your place of work) \_\_\_\_\_  
 Postcode: \_\_\_\_\_  
 All blood types are needed, especially O negative and B negative. Visit [www.blood.co.uk](http://www.blood.co.uk) or call 0300 123 23 23.

**NHS England use only** Patient registered for  GMS  Dispensing

# Victoria Medical Centre

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## New Patient Questionnaire (child)

### IMPORTANT INFORMATION

- IT IS VERY IMPORTANT YOU COMPLETE ALL PARTS OF THIS QUESTIONNAIRE AS ACCURATELY AS YOU CAN.
- FAILURE TO DO SO MAY RESULT IN YOUR REGISTRATION WITH THE PRACTICE BEING DELAYED
- YOU MUST ENSURE YOU HAVE A MONTHS SUPPLY OF MEDICATION FROM YOUR CURRENT PRACTICE BEFORE REGISTERING WITH VICTORIA MEDICAL CENTRE.
- IF YOU ARE TAKING REGULAR MEDICATION YOU MUST SEE THE GP. AN APPOINTMENT WILL BE SENT OUT TO YOU.
- WE DO NOT OFFER NEW PATIENT HEALTH CHECKS WITH THE HCA FOR CHILDREN
- A COPY OF YOUR CHILDS IMMUNISATIONS MUST BE BROUGHT TO RECEPTION WHEN HANDING YOUR FORM IN.

**VICTORIA MEDICAL CENTRE NEW PATIENT QUESTIONNAIRE**

**FOR PATIENTS AGED 15 AND UNDER**

**1. PERSONAL DETAILS**

FIRST NAME(S) \_\_\_\_\_ SURNAME \_\_\_\_\_  
PREVIOUS SURNAME (IF APPLICABLE) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
TELEPHONE NUMBER(S) \_\_\_\_\_

**2. NEW PATIENT APPOINTMENTS**

**You only need to see a GP upon registration if you are on current medication. Please list all medication you take on a regular basis including last issue date:**

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**Please select from the options below so we can send you a convenient appointment:**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	Any specific time?
08:30 – 12:00	07:30 – 11:40	08:40 – 12:10	08:00 – 12:10	08:00 – 11:40	
13:20 – 16:40	14:00 – 19:40	14:00 – 16:50	13:30 – 16:50	14:00 – 16:50	

**PLEASE BRING YOUR MEDICATION WITH YOU TO YOUR APPOINTMENT**

*FAILURE TO ATTEND THE APPOINTMENTS WILL RESULT IN YOUR ATTENDANCE BEING MONITORED. REPEATEDLY MISSING APPOINTMENTS WITHOUT PRIOR WARNING WILL LEAD TO YOUR REMOVAL FROM THE PRACTICE.*

Please list any allergies e.g. to drugs, pollen, animals, food etc. or any medications which have caused you unpleasant side effects.

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**Please fill out the dates of your child's immunisations (to the best of your knowledge). This information will be in your "Personal Child Health Record Book".**

**(Normally given around 2 months of age)**

1<sup>st</sup> Diphtheria/Pertussis (whooping cough), Tetanus – DPT  
Haemophilus influenza type B (HIB)  
Polio  
Pneumococcal Date given .....

**(Normally given around 3 months of age)**

2<sup>nd</sup> Diphtheria/Pertussis (whooping cough), Tetanus – DPT  
Haemophilus influenza type B (HIB)  
Polio  
1<sup>st</sup> Meningitis C Date given .....

**(Normally given around 4 months of age)**

3<sup>rd</sup> Diphtheria/Pertussis (whooping cough), Tetanus – DPT  
Haemophilus influenza type B (HIB)  
Polio  
2<sup>nd</sup> Meningitis C  
2<sup>nd</sup> Pneumococcal Date given .....

**(Normally given 12 months of age)**

Men C/Hib Booster Date given .....

**(Normally given around 13-15 months of age)**

1<sup>st</sup> MMR - Measles/Mumps/Rubella  
3<sup>rd</sup> Pneumococcal Date given .....

**PRE-SCHOOL BOOSTER (Normally given around 3 1/2 – 5 years of age)**

Diphtheria/ Pertussis (whooping cough) Tetanus, Polio Date given .....  
2<sup>nd</sup> MMR - Measles/Mumps/Rubella Date given .....

**SCHOOL LEAVING BOOSTER (Normally given around 14 – 16 years of age)**

Diphtheria/ Tetanus/Polio Date given .....

**PLEASE GIVE DETAILS AND DATES OF ANY OTHER IMMUNISATIONS YOUR CHILD MAY HAVE RECEIVED.**

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**3. FAMILY MEDICAL HISTORY**

Please state any major illness suffered by relatives, whether alive or deceased, particularly heart disease, angina, high blood pressure, diabetes, stroke, cancer (state type) asthma.

**Please add Age, Major Illness, Other Illnesses, Age at death (If applies), Cause of death (If applies)**

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**SMOKING STATUS**

**Do you smoke?**

<b>Yes [ ]</b>	<b>No [ ]</b>
<b>What do you smoke?</b> Pipe [ ] Cigar [ ] E-cig [ ] Rolls own cigarettes [ ] Shop bought Cigarettes [ ]	<b>If no, have you ever smoked?</b> YES [ ] NO [ ]
How many per day? _____	How many per day? _____

**4. SUMMARY CARE RECORD**

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP practice is closed.

For more information regarding the Summary Care Record please speak to one of our members staff or collect a leaflet from the reception desk. Further information is also available at [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk).

**I express consent for medication, allergies and adverse reactions only [ ]**

**I express dissent (I wish to opt out of the Summary Care Record upload) [ ]**

**Signed.....Date.....**

Patient SCRs were uploaded on 19<sup>th</sup> November 2014 and you will automatically be opted into this scheme unless you specify otherwise.

**COMMUNICATION NEEDS**

If you have any specific communication needs (large text etc) please ask the receptionist for a form to complete so we can meet your individual needs as best we can.

## 5. ONLINE SERVICES

### What is Patient Access?

With Patient Access, you can now access your local GP services at home, work or on the move — wherever you can connect to the internet. (Also available on android and iOS). What's more, because Patient Access is a 24 hour online service you can do this in your own time, day or night.

- Book an appointment.
- Order repeat prescriptions.
- Change your address details.
- View your allergies
- View immunisations history.

If you would like to sign up to this service please indicate by ticking the box [ ]. Your log on details will be emailed to you.

EmailAddress: \_\_\_\_\_

Please sign to give consent for your online services being activated \_\_\_\_\_

## 6. TEXT MESSAGE APPOINTMENT REMINDER SERVICE

If you would like to opt in to communication via SMS please sign below. Please note this is NOT limited to appointment reminders and may be used to communicate other information relating to your health record. It is your responsibility to keep mobile numbers accurate and up to date.

Please sign to give consent to receive text message reminder \_\_\_\_\_

If you are providing us with both parents' mobile numbers please indicate here which one we should sent text messages to:

\_\_\_\_\_

## 7. ETHNICITY AND LANUGAGE

**The government now ask us to record your ethnicity.**

**Please delete as necessary:** I agree/do not agree to Victoria Medical Centre recording my ethnicity.

If you agree please tick the appropriate box. This information will be treated in the strictest of confidence.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> British or Mixed British  | <input type="checkbox"/> Other Mixed Background             | <input type="checkbox"/> African                |
| <input type="checkbox"/> Irish                     | <input type="checkbox"/> Indian or British Indian           | <input type="checkbox"/> Other Black Background |
| <input type="checkbox"/> Other White Background    | <input type="checkbox"/> Pakistani or British Pakistani     | <input type="checkbox"/> Chinese                |
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> Bangladeshi or British Bangladeshi | <input type="checkbox"/> Caribbean              |
| <input type="checkbox"/> White and Black African   | <input type="checkbox"/> Other Asian Background             | <input type="checkbox"/> White and Asian        |
| <input type="checkbox"/> Other                     |   |   |

## PREFERRED SPOKEN LANGUAGE

**Please select your preferred spoken language from the list below:**

- |                                    |                                   |                                   |  |   |
|------------------------------------|-----------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> English   | <input type="checkbox"/> Welsh    | <input type="checkbox"/> Gaelic   | <input type="checkbox"/> British Sign Language | <input type="checkbox"/> Makaton Sign Language    |
| <input type="checkbox"/> Akan      | <input type="checkbox"/> Albanian | <input type="checkbox"/> Amharic  | <input type="checkbox"/> Arabic                | <input type="checkbox"/> Bengali & Sylheti        |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Creole   | <input type="checkbox"/> Dutch    | <input type="checkbox"/> Ethiopian             | <input type="checkbox"/> Cantonese and Vietnamese |
| <input type="checkbox"/> Farsi     | <input type="checkbox"/> Finnish  | <input type="checkbox"/> Flemish  | <input type="checkbox"/> French                | <input type="checkbox"/> French Creole            |
| <input type="checkbox"/> German    | <input type="checkbox"/> Greek    | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hakka                 | <input type="checkbox"/> Hausa                    |
| <input type="checkbox"/> Hebrew    | <input type="checkbox"/> Hindi    | <input type="checkbox"/> Igbo     | <input type="checkbox"/> Italian               | <input type="checkbox"/> Japanese                 |
| <input type="checkbox"/> Korean    | <input type="checkbox"/> Kurdish  | <input type="checkbox"/> Lingana  | <input type="checkbox"/> Luganda               | <input type="checkbox"/> Malaysian                |
| <input type="checkbox"/> Mandarin  | <input type="checkbox"/> Pashto   | <input type="checkbox"/> Patois   | <input type="checkbox"/> Norwegian             | <input type="checkbox"/> Portuguese               |
| <input type="checkbox"/> Polish    | <input type="checkbox"/> Punjab   | <input type="checkbox"/> Russian  | <input type="checkbox"/> Serbian / Croatian    | <input type="checkbox"/> Sinhala                  |
| <input type="checkbox"/> Somali    | <input type="checkbox"/> Spanish  | <input type="checkbox"/> Swahili  | <input type="checkbox"/> Swedish               | <input type="checkbox"/> Syheti                   |
| <input type="checkbox"/> Turkish   | <input type="checkbox"/> Thai     | <input type="checkbox"/> Urdu     | <input type="checkbox"/> Vietnamese            | <input type="checkbox"/> OTHER _____              |

**DO YOU REQUIRE AN INTERPRETER FOR YOUR APPOINTMENTS?** YES / NO

**Patient Contact Form to be completed by the child's Parents/Guardians**

<b>Personal Details</b>		<b>Personal Details</b>	
Relationship to patient		Relationship to patient	
Title		Title	
Surname Name		Surname Name	
Forename Name		Forename Name	
<b>Address (if different from patient)</b>		<b>Address (if different from patient)</b>	
House Name/Flat Number		House Name/Flat Number	
House number & Street		House number & Street	
Locality		Locality	
Town/City		Town/City	
County		County	
Postcode		Postcode	
<b>Contact Details</b>		<b>Contact Details</b>	
Home Telephone		Home Telephone	
Work Telephone		Work Telephone	
Mobile Telephone		Mobile Telephone	
<b>Other</b>		<b>Other</b>	
Next of Kin	Y/N	Next of Kin	Y/N
Emergency Contact	Y/N	Emergency Contact	Y/N
Can discuss record	Y/N	Can discuss record	Y/N
Patient of Victoria Medical Centre	Y/N	Patient of Victoria Medical Centre	Y/N

**It would be most helpful if the above information could be completed it is an essential part of the Practice obiding by the Safeguarding Children Act 1989.**

**'The welfare of the child is paramount'**

<b>Check List – UPON RECEIVING THE REGISTRATION FORM</b>	<b>Tick once checked</b>
Practice Leaflet given to patient	
Privacy Notice given to patient	
Communication support form given to patient (if applicable)	
Summary Care Record complete	
Check address	
Check telephone number	
Check previous address (address where registered when at previous GP)	
Check previous GP details	
If patient from abroad -Date pt first came into the UK must be completed	
If patient coming from armed forces – Enlistment date must be completed.	
Check reg form is signed and dated	
Ethnicity form completed	
Preferred Language completed	
Check Smoking Status	
Check Audit C Status (Alcohol Intake)	

Staff name.....Date.....(MUST be completed)

<b>Check List – REGISTRATION CLERK</b>	<b>Tick once complete</b>
Check GP appointment sent	
Check HCA appointment sent	
Check & activate patient access – EMAIL TO PATIENT	
Check & activate SMS	
Summary Care Record	



