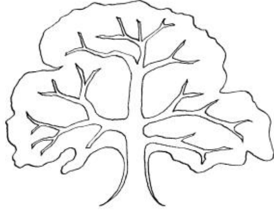


MILE OAK MEDICAL CENTRE

CHALKY ROAD · PORTSLADE · BRIGHTON · BN41 2WF

Telephone: (01273) 426200 Fax: (01273) 426230

www.mileoakmedicalcentre.nhs.uk

IMPORTANT INFORMATION FOR NEW PATIENTS UNDER THE AGE OF 16

Please complete the forms provided fully.

It is essential that you provide us with your NHS number; this can be obtained from your previous doctor's surgery.

NHS

Family doctor services registration

GMS1

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

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

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

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

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

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile 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________/________/________

Version 01/02

Please see overleaf re: Organ donation

NHS # Family doctor services registration

GMS1

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 ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation Date ______/______/______

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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 consent to inclusion on the NHS Blood Donor Register Date ______/______/______

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

.... Postcode: ....

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date ______/______/______

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

General Information:

Telephone numbers [ ]
Parent/Guardian [ ]

Admin:

Allocated GP [ ]
If patient advised of GP when registering (Xab9D) [ ]
SCR Opt in [} Opt Out [ ] recorded in Notes [ ]

Checked by [ ]

Mile Oak Medical Centre – New Patient Questionnaire Child Under 16

It is essential that you complete this form as fully as you can.

Name…………………………………………………………
Male ☐ Female ☐Date of Birth………………........
Address……………………………………………………………………………………………
………………………………………………………………………………………
We may need to contact you from time to time to discuss your child's health care, appointments, test results etc. It is normal practice for us to contact patients by telephone or text message for expediency. This would include leaving a message on your answer phone. If you do not wish to be contacted in this way please advise one of our reception staff and they will record this on your records.

<table>
<tr><th colspan="3">Social and personal information</th></tr>
<tr><td>School/nursery attended details

Home schooled
Yes ☐No☐</td><td colspan="2">Housing type

House ☐
Flat ☐
Bungalow ☐
Other ☐</td></tr>
<tr><td rowspan="3">Mothers name and contact details/address

Fathers name and contact details/address

Does father have parental responsibility?
Yes ☐ No☐ Not sure☐</td><td colspan="2">Who lives at this address with this child?</td></tr>
<tr><td>Name</td><td>Relationship</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Name and address of any siblings under 18?</td><td colspan="2">Has this child or any of their siblings ever been subject to a child protection plan?
Yes ☐ No☐ Please give details</td></tr>
</table>

	Does your child have or has this child ever had a social worker? Yes ☐No ☐ Please give details
Religious belief:	

Your child's health

Please give details of past medical history, illnesses and operations below:	
Does your child have any on-going problems? Yes ☐ No☐	Please give details
Please list **ALL** your child's regular medication, including over the counter medication	List medication here
Does your child have any food allergies or intolerances? Yes ☐ No☐	Please give details

Does your child have any drug allergies? Yes ☐ No☐	Please give details

Immunisations

If your child has had any vaccines privately or outside the UK please list below

Growth and development

Does your child have any problems with their vision, hearing or speech?
Yes ☐ No☐ Please provide details below.

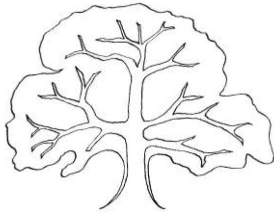
Does your child have any difficulties with their learning?
Yes ☐ No☐ Please provide details below.

Family History

Are there any illnesses that run in the family?

Yes ☐ No☐ Please provide details below.

Please give details of anything else that you think are important for this child



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NEW PATIENT REGISTRATION – ETHNIC BACKGROUND

Please complete this form so that we can have a record of your ethnic background which will be helpful in providing the best medical care for you.

Choose **ONE** section from **A** to **E** below and **tick the appropriate box** to indicate your ethnic group (adding written information if necessary).

A White

- [ ] British
- [ ] Irish
- [ ] Any other White background (please write in)

B Mixed

- [ ] White & Black Caribbean
- [ ] White & Black African
- [ ] White & Asian
- [ ] Any other Mixed background (please write in)

C Asian or Asian British

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Any other Asian background (please write in)

D Black or Black British

- [ ] Caribbean
- [ ] African
- [ ] Any other Black background (please write in)

E Chinese or other ethnic group

- [ ] Chinese
- [ ] Any other (please write in)

NHS Digital

Information for new patients: about your Summary Care Record

Dear patient, or parent/guardian of patient

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. 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 a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

Express consent for medication, allergies and adverse reactions only. You wish to share information about medication, allergies for adverse reactions only.

Express consent for medication, allergies, adverse reactions and additional information. You wish to share information about medication, allergies for adverse reactions and further medical information that 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 and who should be contacted for more information about you.

Express dissent for Summary Care Record (opt out). Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

<u>OR</u>

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would <u>not</u> like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ………………………………………………..........................

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

Surgery name…..……………………… Surgery location (Town): …..……….........

………………………………………………………………………………………

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 above; you sign the form above and provide your details below:

Name: ………...

Please circle one:

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.