The Devonshire Lodge Practice

New Patient Registration Questionnaire for Under 16s

Welcome to our surgery. Please complete this form clearly in capital letters using black ink.

As part of our commitment towards improving health we expect:

- All patients with chronic medical conditions (e.g. diabetes, asthma, epilepsy, etc.) should make an appointment with our nurse as soon as possible.
- If you are on repeat medication please ensure you have at least 4 weeks supply from your current GP to cover the transfer period.

Personal Details

Title: Mr / Miss ______________________ Date of Birth _____________

Sex _________

Forename __________________________ Surname _____________________________

Religion ____________________________ Town & Country of birth _________________

Which school do you attend?

Contact Details

Address ____

____ Post Code ___________

Home Phone ____

Preferred Phone number to contact on: ____

You may receive text / email reminders for your appointments from the surgery. If you do not wish to receive these texts please tick ☐ email alerts please tick ☐

Parents and Carers Details

Parent 1 ________________________________ Phone number ____________________

Address ____

Parent 2 ________________________________ Phone number ____________________

Address ____

Carer's name ____________________________ Phone number ____________________

Address

Can both Parents / Carers have access to Medical Records? Yes / No

If **Not** please state reasons: ____

Emergency Contact Details
Name Relationship Phone No

Siblings
Please give details of the other children in the house

Name	Date of Birth

Carer Status
Do you care for anyone else? Yes / No _______________
If yes, Name of person you care for
____
Do you have anyone who looks after you or your daily needs as Carer?
Yes / No

General Health
Height________________ Weight _________________
Do you have any special dietary requirements? Yes / No Please specify
____
Do you smoke Yes / No Details

Allergies

List any drugs, plasters, food, animals, etc.	Please give details

Past & Present Medical History
Please give details of any chronic medical condition, hospital treatment, accidents, and special investigations

Condition	Month / Year

Immunisations (please circle below)

Please see link re immunisations

https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

if there is anything you think you may/may not have had please let the surgery know as soon as possible.

Parents are requested to please bring in a copy of the Immunisation Records from your child's **Red Book**

Medication

Please list below all Medication you are currently taking or Attach a copy of your Repeat Prescription Request Form (Please ensure you have enough supply for the interim period)

Name	Strength	Dose

The **Electronic Prescription Service (EPS)** is an NHS service.
Are you registered for EPS? Yes / No
If **Yes**, please amend your nominated pharmacy accordingly
If you wish to have further details or an application form, please contact our Prescription Desk once fully registered.

For Office Use Only

Medication checked and approved for entry on Patient's Medical Records ☐
Doctor's signature Date

Ethnic Origin

In compliance with the Race Relations (Amendment) Act 2000 and its Race Equality Scheme, any new patient registrations are requested to complete this section.
Please tick as appropriate to indicate your ethnic origin

British	African	Bangladeshi	Chinese
Mixed British	Carribean	Indian	Other White
Irish	Other Black	Pakistani	Other Mixed
Polish		Siri Lankan	
Other European		Any other ethnicity Please state	

Please state your first **Language**
____

Summary Care Record

I confirm I have received and understood information regarding Summary Care Record and (please tick approriate box) :-

- Express consent for medication, allergies and adverse reactions only
- Express consent for medication, allergies, adverse reaction AND additional information
- Express dissent (opt out) I do not want a Summary Care Record

Name ____________________________ Relationship ________________

(Please sign) ______________________

Thank you for taking time to fill out the questionnaire