



Burbage Surgery

Tilton Road, Burbage, Leicestershire, LE10 2SE
Tel: 01455 634879, Web: www.burbagesurgery.co.uk

****For children up to 16 years of age****

Thank you for applying to join Burbage Surgery. We would like to gather some information about your child and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give your child the best possible care. **Please include a photocopy of the child's birth certificate or a form of identification with the completed form and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. **Please ensure you SIGN and DATE your form.**

****YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION****

*Title: _____ *Surname: _____	*First names: _____
*Any previous surname(s) (if applicable): _____	*Date of Birth: DD / MM / YYYY
* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intermediate <input type="checkbox"/> Unspecified	*NHS No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Town and country of birth: _____	*Home address: _____
*Home telephone No.: _____	*Postcode: _____
Work telephone No.: _____	Email address: _____ (by entering an email address you consent to receive emails sent by our surgery)
*Mobile No. (if you have one): _____	

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

*Previous address in the UK (if applicable): _____ Postcode: _____	*Name of previous doctor: _____ Address of previous doctor: _____
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If your child is from abroad

*First UK address where your child was registered with a GP if your child was previously living abroad: _____ Postcode: _____	*If previously a resident in the UK, date of leaving: _____ *Date your child first came to live in the UK (if applicable): _____
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Is the child a dependant of a current serving member of British Armed Forces? Yes No

Is the child a Looked after Child? Yes No

A child who is being **looked after** by their local authority is known as a **child in care**. They might be living: with foster parents, at home with their parents under the supervision of social services or in residential children's homes.

If you are applying on behalf of a child who is in foster care / residential care / kinship care / or who is not your child

The child is in Foster care <input type="checkbox"/>	The child is in Residential care <input type="checkbox"/>	The child is in Kinship care (looked after by relative) <input type="checkbox"/>
The legal parent or guardian is _____		
The above named person can consent for the medical treatment for the child <input type="checkbox"/>		
Other named person can consent for the medical treatment for the child <input type="checkbox"/> , please specify name _____		

If you are registering a child under 5

I wish the child above to be registered with the doctor named for Child Health Surveillance <input type="checkbox"/>
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What is your child's ethnic group?	Main spoken language (E.g. English):			
White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other White (please specify):	
Black	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other Black (please specify):	
Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian (please specify):
Mixed	<input type="checkbox"/> White + Black Caribbean	<input type="checkbox"/> White + African	<input type="checkbox"/> White + Asian	<input type="checkbox"/> Other mixed:

Next Of Kin / Emergency contact

Are the contacts named below authorised to discuss the child's medical record with us? Yes No

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Carers Information

A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life.

Is the child looked after or supported by someone who they couldn't manage without? Yes No
 If yes, what is their name and contact number?
 Do you consent for the carer to be informed about the child's medical care? Yes No

Does the child look after or support someone who couldn't manage without them? Yes No
 If yes, do they look after someone who is a patient of Burbage Surgery? Yes No Don't know
 If yes, what is their name: Are they a Friend Relative Neighbour

Please detail any contact that the child has with other professionals such as health visitors and social workers:

Medical details

If your child is taking repeat medication, please attach a copy of his/her repeat medication slip. If this is not included with the application, this may affect us being able to issue a further supply. We may request that you make an appointment with a GP before the next prescription is due.

*Is the child allergic to any medicines? Yes No (if yes please specify)

*List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark "none" if the child has no other allergies that you know of):

Has the child ever had any of the following conditions?

Epilepsy	<input type="checkbox"/> Yes	Year
High Blood Pressure	<input type="checkbox"/> Yes	Year
Heart Attack	<input type="checkbox"/> Yes	Year
Angina (stable / unstable)	<input type="checkbox"/> Yes	Year
Stroke	<input type="checkbox"/> Yes	Year
Transient Ischaemic Attack	<input type="checkbox"/> Yes	Year
Cancer	<input type="checkbox"/> Yes	Year

Rheumatoid Arthritis	<input type="checkbox"/> Yes	Year
Mental Illness (inc Depression)	<input type="checkbox"/> Yes	Year
Diabetes (type 1 or type 2)	<input type="checkbox"/> Yes	Year
Asthma	<input type="checkbox"/> Yes	Year
COPD (or Emphysema)	<input type="checkbox"/> Yes	Year
Osteoporosis / Bone Fractures	<input type="checkbox"/> Yes	Year
Peripheral Vascular Disease	<input type="checkbox"/> Yes	Year

List any serious illnesses / operations / accidents / disabilities and the year they took place:

Does your child have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in ground floor consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your child's needs:

Does the child have Family History of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	<input type="checkbox"/> Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	<input type="checkbox"/> Yes	Who
Raised Cholesterol	<input type="checkbox"/> Yes	Who
Stroke / CVA	<input type="checkbox"/> Yes	Who
Asthma	<input type="checkbox"/> Yes	Who
Diabetes	<input type="checkbox"/> Yes	Who

DVT / Pulmonary Embolism	<input type="checkbox"/> Yes	Who
Breast Cancer	<input type="checkbox"/> Yes	Who
Any Cancer Specify type:	<input type="checkbox"/> Yes	Who
Thyroid disorder	<input type="checkbox"/> Yes	Who
Epilepsy	<input type="checkbox"/> Yes	Who
Osteoporosis	<input type="checkbox"/> Yes	Who
Other (please specify)		Who

Please tell us about your child's smoking habits

*Does your child smoke? Yes No
 If Yes, what do they primarily smoke:
 Cigarettes / Cigar / Pipe / Vape (please circle)
 How many do they smoke a day?
 Would you like advice on quitting? Yes No

Is your child an ex-smoker Yes No
 When did they quit?
 How many did they used to smoke a day?

Does your child exercise regularly? Yes No If yes, what exercise do they take and how often:

Communication Preferences

We may want send appointment reminders to your mobile and leave messages on your answering machine, if you have one.
Tick any of these boxes if you DO NOT wish to be contacted in this way:
 Text message Answering machine

Data Sharing

Summary Care Record (SCR)
 As you are registering your child with this practice, we would like to recommend that you take advantage of the Summary Care Record (SCR). The Core SCR includes important information about your child's health: Medicines your child are taking, allergies they suffer from and any bad reactions to medicines.
 You can also choose to have additional information included in your child's SCR, which can improve the care your child receives. This information includes: Your child's illnesses and health problems, operations and vaccinations they have had in the past, how they would like to be treated – such as where you would prefer your child to receive care; what support your child might need and who should be contacted for more information about them.
 Your child may need to be treated by health and care professionals outside of the practice who do not know your child's medical history. Having the additional information SCR can help the staff involved in your child's care access information more quickly, allowing them to make informed decisions about their healthcare. More information can be found by visiting www.nhscarerecords.nhs.uk
 Tick this box if you wish to opt-in your child to the **Core SCR**
 Tick this box if you wish to opt-in your child to the **Core and Additional SCR**
 Tick this box if you wish to opt-out your child from the **SCR**

The Accessible Information Standard (AIS)

Please use this space to tell us about any specific communication needs your child has. i.e. needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

Donor Registration Choices

NHS Organ Donor Registration

"I want to register my child's details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after their death". Please tick the boxes that apply.

- Any of my organs and tissue or...
 Kidneys Heart Liver Corneas Lungs Pancreas

For more information, please visit the website www.uktransplant.org.uk or call 0300 123 23 23

Online Patient Access

Once the application for your child to join our practice has been accepted you'll be able to order repeat medications, book appointments and view certain aspects of your child's medical record online. This service is known as **Patient Access**. To register please download a form from our website or pick one up from reception. You'll be emailed a registration letter within **7 working days**. You'll use this letter to create the online account. Please note **you must have an email address to use this service and given consent to receive emails from Burbage Surgery. The email address cannot be the same as someone else with an account**. Full terms and conditions are available on the back of the application form.

Once your child is registered...

Electronic Prescription Service (EPS)

... you will be able to nominate a pharmacy to collect your child's prescriptions from. EPS enables prescribers, such as GP's and practice nurses, to send prescriptions electronically to a pharmacy of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you have already nominated a pharmacy, please tell us which pharmacy you have chosen. For further information about this service please talk to your pharmacist of choice.

Please record any additional information about you that you think is important for us to know:

***Signed (on behalf of the child):**

***Date** DD / MM / YYYY

FOR OFFICE USE ONLY

Date: _____ Staff Initials: _____

BIRTH CERT. SEEN Or ADDRESS ID SEEN TYPE: _____
Or RED BOOK SEEN