Courtyard Surgery
56 London Road, Horsham, West Sussex, RH12 1AT
Tel: 01403 330320
www.courtyardsurgery.com

NEW PATIENT ADULT REGISTRATION FORM (15 and under)

TITLE & SURNAME: FIRST NAME:

Former Name: Date of Birth:

Gender: NHS No (if known):

House Name/Number:

Road: School/Nursery attended:

Town:

Postcode:

Home Phone: Mobile Phone:

E-mail address:

Ethnicity – please indicate ethnicity

- ☐ White British
- ☐ White Irish
- ☐ Other White background
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White Asian
- ☐ Other Mixed background
- ☐ Indian / British Indian
- ☐ Pakistani / British Pakistani
- ☐ Bangladeshi / British Bangladeshi
- ☐ Other Asian background
- ☐ Black Caribbean
- ☐ Black African
- ☐ Other Black background
- ☐ Chinese
- ☐ Other Ethnic Group
- ☐ Not stated
- ☐ Do not wish to give ethnicity

☐ I give consent to receive messages by text (this will include appointment reminders, messages and general information about the surgery)

☐ I give consent to receive messages by e-mail (this will include messages and general information about the surgery)

I give consent for voicemail messages to be left on my (please indicate): ☐ home phone ☐ mobile telephone

Health Questions

When patients first register, we may not have access to a full past medical history. It would therefore be helpful if you would complete the following section.

Past Medical History – please list any serious illnesses, operations, accidents, or disabilities.

Year:	**Problem:**

COMMUNICATION NEEDS

Does your child have any communication requirements? If yes, please give details. Yes No

Large print Translation Service Sign language Any other (please give details):

How would you like us to communicate and send information to you?

What is your child's first language?

Medication: please give details of any treatments or drugs that your child currently uses. It would be best to provide us with a copy of the current repeat prescription where possible.

Drug Name & Strength	Frequency of Use	Condition Treated by drug:

Drug Allergies – If your child has any allergies or has had any adverse reactions to drugs please let us know.

Drug Name: **Problem Caused:**

Other Allergies:

Pharmacy Nomination.
We can arrange for prescriptions to be sent directly to your chosen Pharmacy.

Name of Pharmacy: **Location:**

OTHER FACTORS AND FAMILY HISTORY

Other Factors **Please tick any of the following conditions that your child suffers from:**	**Family History** *Please list any illnesses that run in your family:*
☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Angina ☐ Heart Attack ☐ Stroke	Mother's side: Father's side: Brothers and Sisters: Other:

Has any member of your immediate family (i.e. mother, father, brothers & sisters) had a heart attack or stroke under the age of 60? If yes, please give details

☐ Yes ☐ No

SAFEGUARDING

Is your child: (please tick where applicable):
Adopted ☐ Yes ☐ No Fostered ☐ Yes ☐ No A looked after child ☐ Yes ☐ No

If you have answered yes to any of the above, please provide copies of court orders and details of parental responsibility.

Named Social Worker: ……

Named Social Care Agency: ……..

Previous GP and Surgery: ……..

Previous Health Visitor: ……..

CHILDHOOD IMMUNSATIONS

Please record your child's immunisations so that they can be added to their medical record. Please can we ask you provide a physical or photocopy of their vaccination history.

Immunisations	**Dose**	**Date given or declined**	
Immunisations completed around 8 weeks old			
Diphtheria / Tetanus / Pertussis	Dose 1		
Polio (By Mouth or Injection)	Dose 1	By Mouth	By Injection
Hib	Dose 1		
Hep B	Dose 1		
Meningococcal B (Men B)	Dose 1		
Rotavirus (By Mouth)	Dose 1		
Immunisations completed around 12 weeks old			
Diphtheria / Tetanus / Pertussis	Dose 2		
Polio (By Mouth or Injection)	Dose 2	By Mouth	By Injection
Hib	Dose 2		
Hep B	Dose 2		
Pneumococcal	Dose 1		
Rotavirus (By Mouth)	Dose 2		
Immunisations completed around 16 weeks old			
Diphtheria / Tetanus / Pertussis	Dose 3		
Polio (By Mouth or Injection)	Dose 3	By Mouth	By Injection
Hib	Dose 3		
Hep B	Dose 3		
Meningococcal B (Men B)	Dose 2		
Immunisations completed around 1 year old			
MMR 1 (measles / mumps /rubella)	Dose 1		
Hib and Men C	Dose 1		
Pneumococcal	Dose 2		
Meningococcal B (Men B)	Dose 3		
Pre-School Immunisations (completed around 3 years 4 months old)			
Diphtheria / Tetanus / Pertussis (pre-school)	Dose 4		
Polio (pre-school) (By Mouth or Injection	Dose 4	By Mouth	By Injection
MMR 2 (measles / mumps / rubella)	Dose 2		
Immunisations completed around 12-13 years old			
Diphtheria / Tetanus / Polio Booster	Dose 5		
Meningococcal ACWY	Dose 1		
HPV			

SHARING AND CONSENT

We would like to obtain your permission and consent to sharing your medical record with NHS England and other healthcare professionals. Please tick your preferences to all items.

Summary Care Record (SCR) – Your Summary Care Record is a short summary of your GP medical records. It tells other health care staff that care for you about the medicines you take and your allergies.
This can help in an emergency, when you're on holiday, out-patient clinics, a pharmacy and when your surgery is closed**.**

☐ I would like to **opt out** of the Summary Care Records Programme and have completed the appropriate form **(please obtain from reception)**
For more information on SCR visit https://digital.nhs.uk/summary-care-records/patients

Consent to Share your Medical Information
At Courtyard Surgery, we use **TPP SystmOne** as our clinical system. Some organisations, including local services such as the Minor Injuries Unit at Horsham Hospital and the District Nursing Team use the same system. With your permission, your GP would be able to see any information recorded by these services as well as those services being able to see your GP record. When you attend a new place of care, your consent will always be sought to enable this sharing.

☐ I am happy to share my data in & out (your GP record will be visible to other organisations that care for you, with your consent, and entries made by other healthcare organisations can be viewed by your GP.

☐ I do not wish to share my data as above

EMERGENCY CONTACTS

We would be grateful if you could give us the details of a person(s) that can be contacted in an emergency – this information will be added to your medical record. Please note that we will not discuss any information without your consent.

Name		
Contact details		
Relationship to child		

PATIENT DISCLAIMER

Thank you for choosing to register at Courtyard Surgery. Your registration will be completed shortly on our clinical system. For further information about the surgery visit our website www.courtyardsurgery.com where you can also see the latest news.

☐ I understand that it is my responsibility to update Courtyard Surgery if any of my details, such as contact numbers or address, change.

Signed: Date:

Print Name: Relationship to child:

SURGERY ADMINISTRATION

Registration form taken in by: Date

Forms of ID seen:

Date registration added to SystmOne: Registered by:

If Safeguarding information completed please pass a copy to Management
Pass Immunisation record to Nicky for data entry

☐ Emergency Contacts / Family members added to Groups & Relationships