**ST ANDREW’S SURGERY CONFIDENTIAL MEDICAL REGISTRATION FORM (UNDER 16)**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Male 🞏 Female

Date of Birth (day/month/year) NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

 (if known)

Town & country of Birth

 Post Code:

Address

Telephone number: Mobile number:

Email address:

We use any of the information given to contact you as necesssary. We use a Text Messaging service to contact patients. To opt out please speak to reception. Unless you opt out this form authourises the practice to use any method available to contact you, including any updated details.

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

Your previous address in UK

 Post Code:

Name of previous Doctor

while at that address

 Post Code:

Address of previous Doctor

**If you are from abroad:**

Your first UK address where

 Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

**If registering a child under 5:**

* I wish the child above to be registered with St Andrew’s Surgery for Child Health Survelliance

**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 to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please ask at reception for an information leaflet or visit the website* [*www.uktransplant.org.uk*](http://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 to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

*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 eg your place of work)*

……………………..………………………………………………………………… Post code: ………………….

**Data sharing consent choices ……**

**vej**

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

In order to provide high quality healthcare and to communicate effectively with patients the surgery would like to use all available communication methods (this includes but is not limited to; appointment reminders, results, patient letters, health recalls and our newsletter). Where you have provided information on how to contact you, please indicate below if you do **not** consent to be sent information by the surgery: (in order to ensure compliance with data protection legislation St Andrews Surgery will not contact children of secondary school age by email or text without consent from the patient)

I do **not** consent to be sent information by email 🞏

I do **not** consent to be sent information by text 🞏

**Signature ……**

**vej**

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient 🞏 Signature on behalf of patient 🞏

**Personal Medical History…..**

Type of Birth:

*(eg normal, forceps, Caesarean*

*If under 5)*

Birth Weight: Feeding:

*(If under 5) (Breast or bottlefed*

 *If under 5)*

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing**  |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations ……**

Please provide details of your childs immunisations with dates if possible (under 5’s). If possible pelase give your Red Book to Reception to photocopy:

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
|  |  |
|  |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |

**Ethnicity ……**

**vej**

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

**Next of kin ……**

**vej**

Name: Tel. contact

 number:

Relationship: