CHILDRENS REGISTRATION FORM

Please fill in all the sections below using **BLOCK CAPITALS**

FULL NAME:	
DATE OF BIRTH:	
HOME ADDRESS:	

ETHNIC ORIGIN:	☐ British/Mixed British	☐ Irish
	☐ Other White Background	☐ White & Black African
	☐ White & Black Caribbean	☐ Black African
	☐ Black Caribbean	☐ Other Black Background
	☐ Bangladeshi	☐ Indian
	☐ Pakistani	☐ Chinese
	☐ White & Asian	☐ Other Asian Background
	☐ Other Mixed Background	☐ Rather Not Say
	☐ Other (Please Specify)	
RELIGION:		
SPOKEN LANGUAGE:		
DO YOU REQUIRE AN INTERPRETER?	☐ YES ☐ NO	

KNOWN DISABILITIES OR HEALTH CONDITIONS:	

NEXT OF KIN/PARENTAL RESPONSIBILITY:

NAME:	
CONTACT NUMBER:	
RELATIONSHIP TO PATIENT:	
DO YOU HAVE PARENTAL RESPONSIBILITY?	☐ YES ☐ NO

CONTACT PREFERENCE(S):	☐ PHONE ☐ SMS ☐ POST ☐ EMAIL ☐ VIA CARER/NEXT OF KIN

SIGNATURE OF PARENT/GUARDIAN	
DATE:	

Please make sure to also sign the purple GMS1 form attached to this registration pack

Please note that children must have at least one parent/carer registered at the practice under the same address

ACCEPTABLE FORMS OF ID

☐ Passport ☐ Birth Certificate

FOR ALL CHILDREN UNDER 5 YEARS OLD PLEASE BRING THE CHILDS RED BOOK WITH YOU AT REGISTRATION SO WE CAN TAKE A COPY OF THEIR IMMUNISATION HISTORY

A copy of these will be taken and stored electronically with your medical record – we will only copy relevant information and once this is scanned to record it will be destroyed confidentially. If you are struggling to provide this information please speak to a member of staff at reception.
For more information regarding our confidentially, dignity, equality or privacy policies please contact Hope Citadel Healthcare CIC via info@hopecitadel.org.uk

NEXT STEPS:

- Once you have handed this completed form into reception your child will be registered within 48 working hours
- Children under 16 do not need to have a new patient medical so can be seen by GPs right away
- It is your responsibility to keep your childrens contact details up to date to ensure that we are able to contact you when necessary – forms are available at reception to update your details at any time.
- If you would like an account to book appointments, order medications and view your childrens immunisations and allergies online please speak to our reception team to set this up. Please note that you must have an active patient access account already to become a proxy user for another patient.

FOR OFFICE USE ONLY

TAKEN IN BY		DATE	
ID SEEN/COPIED	☐ YES ☐ NO	NPM DATE	
REGISTRATION DATE		EMIS NUMBER	

Consent to Proxy Access to GP Online Services

This form allows parents, guardians and carers of our patients to order prescriptions and book appointments online as a proxy (*representative*). To be eligible for this you must have an active online patient access account; you will use your own log in details to access the proxy account.
A proxy account can be created for

- a child under 11 years old that you are the parent/legal guardian for
- a child between 11 and 16 years old who has given permission
- a child between 11 and 16 years old that the GP has carefully assessed and decided that they are not capable of making their own decisions regarding their medical care
- an adult aged over 16 that has given full, informed and written consent for their carer or representative to manage their medical care
- an adult aged over 16 that the GP has carefully assessed and decided that it is in the best interest of the patient/they lack capacity to manage their own medical care

This account will remain active until the patient turns 11 years old; after this we will then need to verify that the patient would still like you to be their proxy user.
Once the patient turns 16 the account will be **automatically deactivated**; if you would still like access to this account you will need to complete a new form and we will need the consent of the patient to continue.

If you require access for more than one patient, or you would like more than one representative to have proxy access please complete a form for each patient/proxy user

The Patient:

NAME	
DOB	
ADDRESS	
TELEPHONE NUMBER	
MOBILE NUMBER	

The Representative: (YOU)

NAME	
DOB	
ADDRESS	
TELEPHONE NUMBER	
MOBILE NUMBER	
EMAIL ADDRESS *please print clearly*	
PHOTO ID SEEN?	☐ YES ☐ NO

Declaration:

for patients over 16 – if this is for a patient under 16 please go straight to the representative declaration

I _____ (*name of patient*), give permission to Birtle View Medical Practice to give the above named person proxy access to my online services as indicated below.

BOOKING APPOINTMENTS	☐
REQUESTING REPEAT PRESCRIPTIONS	☐
ACCESSING MY SUMMARY CARE RECORD	☐

I understand that I have the right to revoke this proxy access at any given time. I understand the risks of allowing someone else to have access to my health records.

SIGNATURE OF PATIENT	
DATE	

Representative Declaration:

I _____ (*name of representative*), wish to have online access to the services indicated above for the above named patient. I understand my responsibility for safeguarding sensitive medical information. I understand and agree with the following statements:

I will be responsible for the security of the information that I see or download	☐
I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement	☐
If I see information in my record that is not about the patient, or is inaccurate, I will log out immediately and contact the practice as soon as possible	☐

SIGNATURE OF REPRESENTATIVE	
DATE	

FOR PRACTICE USE ONLY

Identity verified through *(tick all that apply)*	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	**Name of verifier**	**Date**
Name of person who Authorised *(if applicable)*			**Date**
Date account created			
Date passphrase sent			

Information for New Patients: about your Summary Care Record

Dear 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 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 outline 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 and 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 this 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 information regarding your choices, please choose **one** of the option 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.

or

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

No – I would not like a Summary Care Record

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

Name of Patient			
Date of Birth		**Patient's Postcode**	
Surgery Name	Birtle View Medical Practice	**Surgery Location**	Heywood
NHS Number (if known)			
Signature		**Date**	

If you are filling this form out 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:

I am the:

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.

For GP practice use only

To update the patients consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo	XaXj6