|  |  |  |
| --- | --- | --- |
| **Dr C Mears** MBBS MRCGP DRCOG DFFP DCH**Dr M N Iqbal** MBBS MRCGP**Dr H Dahl** MBBS MRCGP**John Snaith**Practice Manager*www.swarlandavenuesurgery.nhs.uk* |  | **Swarland Avenue Surgery**2 Swarland AvenueBentonNewcastle upon TyneNE7 7TDTelephone: (0191) 215 0141Fax: (0191) 266 1358Email: swarland.avenue@nhs.net |

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**NEW PATIENT REGISTRATION QUESTIONNAIRE FOR UNDER 12’s**

**Date:** \_\_\_/\_\_\_\_/\_\_\_

**FULL NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**TEL NO. HOME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOBILE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I CONSENT TO BE CONTACTED BY SMS MESSAGES: YES:** **[ ]  NO:** **[ ]**

**NAME OF PARENT/ GUARDIAN :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TEL NO: HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of previous GP surgery:**

**Who else lives in the household?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have a social worker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your child subject to a Child Protection Plan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What school or nursery does your child attend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you object to your child’s summary care record being available when you access NHS care outside of your GP Practice** (for example NHS Out of Hours Services or Accident & Emergency)? **YES/NO**

Your electronic record can be used by authorised staff in other areas of the health and care system that are involved directly with the patient to provide better care.

(If you choose to opt out please ask for opt out form from reception)

Admin only – Yes 9Ndm / No 9Ndo / No preference 9Ndl

**Is your child taking any regular medications? If so which ones?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have any allergies?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has your child had any illnesses, operations or accidents?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which ethnic group do you feel your child belongs?**

**WHITE ASIAN or ASIAN BRITISH**

 **British Indian**

 **Irish Pakistani**

 **Any other, write below Bangladeshi**

 **Any other, write below**

**MIXED**

 **White and Black Caribbean BLACK or BLACK BRITISH**

 **White and Black African Caribbean**

 **White and Asian African**

 **Any other, write below Any other, write below**

**CHINESE**

 **Chinese I do not wish to answer this question**

 **Any other, write below**

**What is/ will be this child’s main spoken language?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This is the language you speak in your home or family environment; regardless of how well you speak English.

**Any other language**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*IMMUNISATIONS**

**Please can you bring your child’s red book (My personal child health record) with you at the point of registration or alternatively provide a photocopy of your child’s immunisations from your previous practice.**

**Immunisations been provided?** Yes [ ]  No [ ]

For office use only:

Has photographic ID been verified Yes [ ]  No [ ]

Has proof of address been verified Yes [ ]  No [ ]

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_