Garden City Surgery UNDER 16S

57-59 Station Road
Letchworth Garden City
SG6 3BJ

REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK & IN CAPITALS

Surname: ..... First Names: .....

Home Tel: *(Landline only)*..... Work Tel: .....

Mobile Tel: ..... Email: .....

Preferred contact method: Letter/Email/SMS (*circle as required*)

Does your child have any information or communication needs? Yes/No

How can we meet your needs ?.....

Consent to use mobile number for text alerts: ☐ *(please tick if you consent)* (XaQid)

What is your Nominated Pharmacy? (*Name & Address*) .....

.....

First Language:

English		Gujarati		Punjabi	
Polish		Hebrew		Sinhala	
Bengali & Sylheti		Hindi		Somali	
Spanish		Portuguese		Tamil	
Cantonese		Italian		Swahili	
Cantonese		Japanese		Swedish	
Vietnamese		Korean		German	
Creole		Kurdish		Tagalog (Filipino)	
Dutch		Greek		Turkish	
Urdu				Other (*please state*)	

Ethnic Origin: (please tick)

White British		Irish	
British/Mixed British		White & Black Caribbean	
Other White		Caribbean	
White & Black African		Other Black	
African		Indian/British	
White & Asian		Bangladeshi/British	
Pakistani/British		Other Mixed	
Other Asian		Other	
Chinese		Would prefer not to say	

Are you a carer? Do you look after someone who relies on you for support? Yes / No

Who do you care for? .....

Do you have a carer? Yes / No Carer's name:.....

Carer's Address:

.....

Contact No: .....

Child's Next of Kin & their relationship to your child

Name.....

Relationship to your child.....

Their Address:

.....

Contact No:.....

Medical History: **(We require full access to your records and also permission to share your records with other health care providers under the NHS umbrella to be able to provide you with our services).**

Does your child have any **current medical problems**? Yes / No

Details:

.....

.....

.....

Is your child taking any **medication**? Yes / No

If yes, please provide a copy of your repeat list.

Does your child have any **allergies**? Yes / No

Details:

.....

.....

.....

By signing below, you consent to share your record in to the practice's IT systems and out to other NHS Healthcare providers.

Signed: .....

Thank you for completing this questionnaire

OFFICE USE:

	DATA ENTERED		
Nominated Pharmacy	YES / NO	Removed as Out of Area	
Preferred method communication			
Consent to text - XaQid			
NOK information			
Ethnicity			
First language			
Information or communication needs			
Is a Carer			
Has a Carer			
Allocated GP			
Named GP			
SCR informed dissent			
Registration Completed by & date			
Registration Checked by & date			