DockhamRoad Surgery

New Patient Registration Form Addendum

(Child/Young Person: under 18 years)

Whilst we are waiting for your child's full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that your child's care is transferred as seamlessly as possible.

Please complete in **BLOCK CAPITALS** and tick relevant boxes.

- Please complete a separate form for each child/young person to be registered.
- Please bring in your child's red book so we can take a copy of their immunisation record.
- When handing in please remember to bring photo ID & proof of address of registering adult.
- We automatically share all children under the age of 16s records with other health professionals. Please inform us if you object to this information sharing.

Your Child/Young Person's Personal Details

Title			
Full Name			
Date of Birth			
NHS No (if known)			
Gender	☐ **Female**	☐ **Male**	☐ **Other**
Current Address			
Home tel. number			
Mobile tel. number			
E-mail address			

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Required Information

Name of Parent(s)/Carer(s)	Has legal Responsibility?	Next of kin?
1.	Yes/No	Yes/No
2.	Yes/No	Yes/No
Name of person(s) with legal responsibility if not above:		
Please give copy of Delegation of Consent Form if you are a carer.		
Name of School/Nursery attended:		
Is child/Young Person home educated?	☐ Yes	☐ No

Please list other family members at your address		
Name	**Registered with us?**	
1.	☐ Yes	☐ No
2.	☐ Yes	☐ No
3.	☐ Yes	☐ No
4.	☐ Yes	☐ No
5.	☐ Yes	☐ No
6.	☐ Yes	☐ No

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Your Child's Medical Background.

Does your child/young person need help with mobility/communication?	☐ Yes	☐ No
If No, please go to next question		
Does your child use:	☐ Wheelchair ☐ Walking aid	
Please specify:		
☐ Hearing Aid ☐ British Sign Language (BSL) ☐ Makaton Sign Language		
☐ Lip reading ☐ Large print ☐ Braille ☐ Interpreter ☐ Other		
Is your child currently housebound?	☐ Yes	☐ No
If so, please provide details below:		

Please give information about any serious illnesses, operations, or injuries your child/young person has had in the past. *If none, please go to next question*		
Condition:	Year Diagnosed:	Ongoing: ☐ Yes ☐ No

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Please provide details of any medication your child takes (including the contraceptive pill):		
Name	**Dosage**	**Frequency**

Please give details of any allergies or sensitivities your child may have to medication/food:

Is your child registered with a dentist?	☐ **Yes**	☐ **No**

To find a dentist visit NHS Choices www.nhs.uk

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Is your child/ young person known to Social Services?	☐ Yes	☐ No
If No, please go to next question		
Is your child or family currently involved with Children's Services?	☐ Yes	☐ No
If yes, please give further details:		
Name of Social Worker:		
Is your child/young person a Looked After Child in the care of the Local Authority?	☐ Yes	☐ No
If yes, in what capacity?	☐ Permanent	☐ Temporary
Which Local Authority?		
Name of Social Worker:		
Is your child being looked after by a friend, family member, or neighbour in their home (Private Fostering)?	☐ Yes	☐ No
If so, how long have they been there?		
Is your child looking after someone at home?	☐ Yes	☐ No

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Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems.		
If so, do you think they would like additional support as a Young Carer?	☐ **Yes**	☐ **No**