Dr I A Bernstein
Dr V M Ramage
Dr N A Qureshi
Dr R S Ramanathan
Dr S Myint
Dr E Novitt
Dr E Davison
Miss Furiha Chaudry

NEW PATIENTS REGISTRATION FORM
CHILDREN UNDER 16 YEARS

Gordon House Surgery
Mattock Lane Health Centre
78 Mattock Lane
Ealing, London
W13 9NZ

Tel: 020-8799 5699
www.gordonhouse.nhs.uk

OUR MISSON IS TO PROVIDE AN EXCELLENT EXPERIENCE OF HIGH-QUALITY HEALTHCARE.

CODE OF BEHAVIOUR FOR PATIENTS & VISITORS

"THE PRACTICE AIMS TO GIVE ITS PATIENTS HIGH QUALITY CARE IN A SECURE ENVIRONMENT. WHILST YOU ARE IN OUR CARE OR VISITING OUR PREMISES YOU HAVE THE RIGHT TO EXPECT COURTESY AND CONSIDERATION FROM OUR STAFF AND FROM OTHER PATIENTS AND VISITORS, AND THEY HAVE THE RIGHT TO EXPECT THE SAME COURTESY AND CONSIDERATION FROM YOU"

Dear Patient,
There are seven key principles that guide the NHS in all it does:

1. The NHS provides a comprehensive service, available to all
2. Access to NHS services is based on clinical need, not an individual's ability to pay
3. The NHS aspires to the highest standards of excellence and professionalism
4. The patient will be at the heart of everything the NHS does
5. The NHS works across organisational boundaries
6. The NHS is committed to providing best value for taxpayers' money
7. The NHS is accountable to the public, communities and patients that it serves

They are underpinned by core NHS values: Working together for patients, Respect and dignity, Commitment to quality of care, Compassion, Improving lives & Everyone counts.

We believe that the practice and patients both have rights and responsibilities to ensure a friendly, courteous and efficient service provided under a safe environment. Below are some responsibilities that patients and the practice should always follow.

THE NHS CONSTITUTION
the NHS belongs to us all

PATIENTS AND THE PUBLIC – YOUR RESPONSIBILITIES THE NHS BELONGS TO ALL OF US. THERE ARE THINGS THAT WE CAN ALL DO FOR OURSELVES AND FOR ONE ANOTHER TO HELP IT WORK EFFECTIVELY, AND TO ENSURE RESOURCES ARE USED RESPONSIBLY

1. Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.
2. Treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
3. Provide accurate information about your health, condition and status. Please keep appointments or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
4. Follow the course of treatment which you have agreed and talk to your clinician if you find this difficult.
5. Participate in important public health programmes such as vaccination.
6. Ensure that those closest to you are aware of your wishes about organ donation.

PATIENT RESPONSIBILITIES:

- You have the right to explanations of your illness and any investigations relevant to that illness. If you require referral to a specialist you will be offered a choice, in accordance with the NHS 'Choice and Booking' agenda.
- You should treat ALL practice staff and other patients with courtesy and respect at all times.
- As this is a busy practice, please be patient if the Clinician is running late. If you arrive up to 10 minutes late for your appointment, we will endeavor to retain your appointment slot and send you in to see the Doctor/Nurse as soon as possible, you may have to wait if others patients attend on time for their appointments.
- If you arrive more than 10 minutes late for your appointment your turn may be lost you will have to rebook your appointment.
- All repeat medication should be ordered within a MONTH prior to medication running out. Please allow THREE COMPLETE WORKING DAYS before collecting the prescription. Repeat medication will only be issued when due, in accordance with dose indicated by your clinician.
- Please ensure a single appointment is for ONE person and ONE problem only. If you have more than one medical problem please request a longer appointment.
- Please note that the first seven days of any sickness a self-certificate is sufficient. However, if requested a private certificate may be issued and appropriate fee charged.
- All Non-NHS services will incur charges depending on the service requested, please confirm the agreed fee with staff before proceeding with your request. Any private report etc. is provided on the basis of your medical conditions and fees are charged in respect of time spent preparing such reports, therefore fees are non-refundable.
- Talk to us about complaints, suggestions and feedback. We are always looking to develop and support out patients.

PRACTICE TEAM RESPONSIBILITIES:

- We aim to treat all patients and staff with respect and courtesy, irrespective of his/her ethnic origin, religious beliefs, personal attributes, or the nature of health problem
- We will maintain your right to privacy and confidentiality and will not discuss your illness with other staff members on an unprofessional basis.
- Help you make an informed decision about your health and advise on treatment in a timely manner
- Keep up to date with the developments in the community and in line with our local CCG's aim and objectives
- Treat you with compassion and dignity at all times
- Appointments options include Face to face, video and telephone consultation. We offer 24/7 Online consultation via eConsult via our website **www.gordonhouse.nhs.uk**
- Receptive to feedback both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve services for all.

WE OPERATE ON A ZERO TOLERANCE POLICY TO ABUSE IN THE NHS. PATIENTS WHO DISPLAY UNACCEPTABLE BEHAVIOUR OR VIOLENCE TOWARDS STAFF OR OTHER PATIENTS WILL BE REMOVED FROM THE LIST IN LINE WITH NHS ENGLAND GUIDANCE ON ACCEPTABLE BEHAVIOUR.

Please sign below if you accept these terms and conditions.

Name	**Signature**
Date / /	

NEW PATIENT REGISTRATION FORM (CHILDREN UNDER 16 YEARS)

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

1 YOUR DETAILS

NHS Number

Title: ☐ **Master** ☐ **Miss** ☐ **Other:**_____

First Name(s):

Surname:

Mothers name if different:

Country of birth:

Town of birth

Borough (*If born in London):

Gender: Male ☐ **Female** ☐

Other:_____

Date of Birth: / /

Current Address:

Postcode:

Home tel. number:

Mobile tel. number:

Can we use the above mobile number to send appointment reminders and health promotion details?

Please tick here if you do not wish to receive messages from us: ☐

IF YOU CHANGE YOUR MOBILE NUMBER, PLEASE UPDATE THE SURGERY AS SOON AS POSSIBLE.

How would like us to contact you about your child,

Indicate 1st Choice: Letter ☐ **SMS Text** ☐ **Phone** ☐

NEXT OF KIN (PLEASE PROVIDE TWO CONTACTS)

[1] Next of Kin Name:

Relationship to Patient:

Next of Kin contact tel. number:

Is your Next of Kin, registered here?

Yes ☐ **No** ☐

[2] Next of Kin Name:

Relationship to Patient:

Next of Kin contact tel. number:

Is your Next of Kin, registered here?

Yes ☐ **No** ☐

Please list other Family/Relatives living at above address, who are registered with us:

[1] Relationship:

Name:

Date of Birth: / /

[2] Relationship:

Name:

Date of Birth: / /

If you have more relatives, please attach on a separate page with this form

2 REQUIRED INFORMATION

Name of parent/s	[1] Mother	
	[2] Father	
Name of person with legal parental responsibility:		
Name of school attended:		

3 YOUR CHILDS RELIGION (PLEASE TICK)

- ☐ C of E
- ☐ Sikh
- ☐ Catholic
- ☐ Jewish
- ☐ Other Christian *PS_ _ _ _ _ _ _ _ _
- ☐ Jehovah's Witness
- ☐ Buddhist
- ☐ Hindu
- ☐ Muslim
- ☐ No religion
- ☐ Other religion *PS_ _ _ _ _ _ _ _ _

YOUR CHILD ETHNIC ORIGIN (PLEASE TICK ONE)

- ☐ White (UK)
- ☐ White (Irish)
- ☐ White (Other)
- ☐ Black Caribbean/British
- ☐ Black African / British
- ☐ Other Black Background
- ☐ Indian/British Indian
- ☐ Arabic
- ☐ Other Mixed Background
- ☐ Pakistani
- ☐ British Pakistani
- ☐ Bangladeshi / British Bangladeshi
- ☐ Chinese
- ☐ Other Asian Background
- ☐ Other
- ☐ Ethnic Category Refused

What is your main spoken language?

Do you speak English? Yes ☐ No ☐

Do you need an Interpreter? Yes ☐ No ☐
If Yes, Which language:

DO YOU NEED HELP WITH MOBILITY/HEARING/SPEAKING? (TICK ALL THAT APPLY)

☐ Wheelchair	☐ Walking aid	☐ Hearing aid	☐ British sign language (BSL)
☐ Lip reading	☐ Large print	☐ Braille	☐ Other *PS _ _ _ _ _ _ _ _ _ _ _
Is your Child currently?	☐ Homeless	☐ A Refugee	☐ An Asylum Seeker
Is your Child Housebound? Yes ☐ No ☐			☐ Makaton sign language

Please list countries, outside of the UK, that you have visited/lived in for more than 6 months during the past 5 years

	Countries	Dates/Year (If known):
1		/ /
2		/ /
3		/ /
4		/ /
5		/ /

4

LOOKING AFTER SOMEONE

Is your Child looking after someone, who is unwell, frail, disabled or has mental health, or substance misuse problems? May need emotional support.	☐ Yes ☐ No
Is your child cared by, someone other than yourself?	☐ Yes ☐ No

Carer's Name:

Carer's Relationship to you:

Carer's Telephone number

5

MEDICAL BACKGROUND

Does your Child, or any of your family, have any of the following medical conditions, for example parents, grandparents, siblings? Tick all that apply *and* state family members:

Diabetes ☐ Who?	**Asthma ☐ Who?**	**Thyroid disorder ☐ Who?**	**Stroke ☐ Who?**	**COPD ☐ Who?**
Heart Attack under the age of 60 ☐ Who?	**Cancer, Specify type ☐ Who?**	**High Blood pressure ☐ Who?**	**Any other important family illness. *Please state*: _____**	

Does your Child have any chronic medical conditions?

1	
2	
3	

Date of Diagnosis:

	/ /
	/ /
	/ /

Has your Child had an operation in the last 2years?

1	
2	
3	

Date of operations:

	/ /
	/ /
	/ /

What injuries has your child had?

1	
2	
3	

Date of injuries:

	/ /
	/ /
	/ /

Please lists any, medicines, or treatments your Child is currently undertaking:

ALLERGIES OR SENSITIVITIES ANY TO DRUGS

Please specify?

If yes, please book an appointment with the clinician for a registration medical assessment

Your child, able to use Medication ☐ **Your child, unable to use Medication ☐**

We can now send your prescriptions electronically to the pharmacy of your choice.

Consent given for Electronic Prescription Service ☐ **Declined consent for Electronic Prescription Service ☐**

If you would like us to do this, please give the name, address and postcode of the pharmacy here:

6	WHICH VACCINATIONS HAS YOUR CHILD HAD?					
	Age	**Immunisation**	**Date (DD/MM/YY)**	**GP Surgery**	**Private**	**Abroad**
	At Birth	**Vitamin K**		☐	☐	☐
		BCG		☐	☐	☐
	2 months	**1st Diphtheria, Tetanus, Pertussis**		☐	☐	☐
		1st Polio		☐	☐	☐
		1st HIB		☐	☐	☐
		1st Pneumococcal Vaccine		☐	☐	☐
		1st Rotavirus		☐	☐	☐
		1st Meningitis B		☐	☐	☐
	3 months	**2nd Diphtheria, Tetanus, Pertussis**		☐	☐	☐
		2nd Polio		☐	☐	☐
		2nd HIB		☐	☐	☐
		1st Meningitis C		☐	☐	☐
		2nd Rotavirus		☐	☐	☐
	4 months	**3rd Diphtheria, Tetanus, Pertussis**		☐	☐	☐
		3rd Polio		☐	☐	☐
		3rd HIB		☐	☐	☐
		2nd Pneumococcal Vaccine		☐	☐	☐
		2nd Meningitis B		☐	☐	☐
	12 months	**Hib/Men C Booster**		☐	☐	☐
		3rd Meningitis B		☐	☐	☐
	13 months	**MMR (Measles, Mumps, Rubella)**		☐	☐	☐
		3rd Pneumococcal Vaccine		☐	☐	☐
	3½ to 5 Years	**MMR Booster (Measles, Mumps, Rubella)**		☐	☐	☐
		Pre-School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐
	13-18 Years	**Booster Diphtheria, Tetanus & Polio**		☐	☐	☐
		1st Meningitis A		☐	☐	☐
		Meningitis C		☐	☐	☐
		1st Meningitis W		☐	☐	☐
		1st Meningitis Y		☐	☐	☐

9	**SHARING YOUR CHILD'S MEDICAL RECORD**

An informed patient, in consultation with a Healthcare Professional, can choose to permit or restrict access to the information entered into their record at each organisation that accesses their record.
The patients' Parent/guardian will be asked to give their record sharing consent at each organisation at which they receive care.
The patients' Parent/guardian can change consent at any time.

Sharing Out

Does the Parent/guardian of the patient consent to the sharing of data recorded here with any other organisations that may care for your child?

☐ **YES –Share data with other organisation** ☐ **NO – Do not share any data recorded here**

Sharing In

Does the Parent/guardian of the patient consent to the viewing of data by this organisation that is recorded at other care services that may care for your child where the Parent/guardian of the patient has agreed to make the data shareable?

☐ **Consent given** ☐ **Consent refused**

WE DO NOT TAKE COPIES OF ANY PERSONAL DOCUMENTATION,
ONLY BIRTH CERTIFICATES FOR NEW BORNS

10	**DECLARATION AND SIGNATURE**

I CONFIRM THAT I HAVE COMPLETED THIS FORM AS ACCURATELY AS POSSIBLE AND WOULD LIKE TO REGISTER MY CHILD AS A PATIENT AT THIS PRACTICE.

PRINT FULL NAME

Parent/Guardian signature:

_____

Date: / /

11	**PARENT / GUARDIAN PERMISSION GIVEN**

Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?

Name of person/s:

Relationship:

Parent / Guardian Signature:

CHECKLIST

THANK YOU FOR COMPLETING THIS FORM. PLEASE CHECK YOU HAVE COMPLETED ALL SECTIONS WHERE POSSIBLE. PLEASE ENSURE THAT YOU BRING THE FOLLOWING WITH YOU TO THE SURGERY TO COMPLETE YOUR REGISTRATION:

1. **COMPLETED & SIGNED NEW PATIENT REGISTRATION FORM** ☐
2. **COMPLETED & SIGNED GMS1 FORM** ☐
3. **PHOTOCOPY, OF YOUR CHILD'S BIRTH CERTIFICATE** ☐
4. **IF POSSIBLE, YOUR CHILDS IMMUNISATION RECORDS (THIS ONLY APPLY'S TO CHILDREN BORN OUTSIDE OF THE UK)** ☐
5. **IF RELEVANT, YOUR CHILDS REPEAT MEDICATION REQUEST SLIP FROM YOUR PREVIOUS GP OR PHARMACY** ☐

Thank you for completing this form

For more information about the services we offer, please refer to our practice leaflet or see our website www.gordonhouse.nhs.uk

OFFICE USE ONLY

APPOINTMENT INFORMATION		
6/8wk check.	**Date :_____**	**Time: _____ Clinician _____**
First Imms.	**Date :_____**	**Time: _____ Clinician _____**
New Patient, medical.	**Date :_____**	**Time: _____ Clinician _____**

VERIFICATION OF PATIENT ID & PROOF OF ADDRESS		NOMINATED GP
☐ **Birth Certificate**	☐ **Other**	☐ **Patient advised**

STAFF DETAILS	
Received and checked by **STAFF NAME:**	**Date received:** ☐☐/☐☐/☐☐☐☐