Scott Road Medical Centre Registration Form Age 0-16
PLEASE COMPLETE THIS FORM IN FULL USING BLOCK CAPITALS

In order to process your application form we will require a copy of your Birth Certificate

Have you ever been registered at this practice before? Yes ☐ No ☐

Contact Information	
Childs name	
Date of Birth	
Parents name	

I consent to receiving SMS text messages from Scott Road Medical Centre regarding appointment reminders and relevant health invitations. (Please tick) consent ☐ Dissent ☐

We occasionally use your email address to communicate with you about your direct medical care.

We can also email you other useful information unrelated to your direct medical care - for example surgery newsletters, surgery information, staff changes and minutes from patient participation meetings.
If you would like to receive this information please consent below.

I consent to receiving emails from Scott Road Medical Centre regarding Non-medical information (Please Tick) ☐

We never pass your email onto any third parties (unless you have given us your explicit consent to do so)
You can withdraw consent at any time by informing Reception.

Do you have repeat Medication?

All prescription are now sent electronically to a pharmacy of your choice, please nominate a pharmacy.	Pharmacy Name & Location

Specific Needs: This is to enable us to accommodate your needs. Please specify any specific requirements you may require below.	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight)	
Are you an assistant dog user?	
Please state any Physical/Mental disabilities?	
Do you have any access requirements?	
Do you have any phobias?	

Are you a Carer?

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**
If you are a Carer, please state your name/address/phone number of the person who you care for:	**Person Cared for Contact Details:**

Ethnicity – Please tick only 1 box			
White	British	☐	XaJQv
	Irish	☐	XaJQw
	Any other white background	☐	XaJQx
Mixed	White & Black Caribbean	☐	XaJQy
	White & Black African	☐	XaJQz
	White & Asian	☐	XaJR0
	Any other mixed background	☐	XaJR1
Asian or British Asian	Indian	☐	XaJR2
	Pakistani	☐	XaJR3
	Bangladeshi	☐	XaJR4
	Any other Asian background	☐	XaJR5
Black or Black British	Caribbean	☐	XaJR6
	African	☐	XaJR5
	Any other background	☐	XaJR8
Any Other Ethnic Background	Chinese	☐	XaJR9
	Any other (please describe)		XaJRA
Do not wish to state ethnicity		☐	XE0oc

Family History - Please tick ANY box that applies to you	
A member of my family suffers from Diabetes Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Hypertension Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Heart Disease and this started BEFORE they were 60 years of age Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐
A member of my family suffers from Asthma Family member who suffers from this condition e.g. Father, Mother, Brother, Sister	☐

Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for improving services. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.	
Yes I am interested in becoming involved in the Patient Participation Group and would like to be contacted by a representative from the group (please tick)	
You can opt out at any time, please contact us here at the surgery. This will not affect any other care we provide for you.	

Summary Care Record (SCR)

The objective of a Summary Care Record is to share key information from your GP records. This enables other NHS services such as A&E or Out of Hours to access your essential health information as and when required. This is particularly beneficial to you in an unplanned or emergency situation.

There are two types of Summary Care Records, which are 'Standard Core' and 'Enhanced Core'. Both require consent.

What is 'Standard Core' Summary Care Record?

This includes sharing your current and repeat medications, any allergies you suffer from and any harmful reactions to medication you have experienced.

I consent to share my 'Standard Core' Records ☐ I dissent to share my Records ☐

What is 'Enhanced Core' Summary Care Records?

This includes sharing your 'standard core' records with additional information such as; reason for medication e.g. why a patient needs a particular medication, long term health conditions for e.g. Asthma, Diabetes, Heart problems and rare medical conditions, Significant/relevant medical history. (Past and present) e.g. procedures, operations and long term conditions, communication preferences e.g. interpreter required, email/text/braille only, End of life care info e.g. the patient may have their own care preferences, which will enable us to care for them more in line with their needs e.g. preferred place of death/DNACPR/advanced care plan. Vaccinations and immunisations e.g. details of previous vaccinations, such as Tetanus and childhood jabs. Personal preferences e.g. religious beliefs or legal decisions that you would like to be known.

I consent to share my 'Enhanced Core' Records ☐ I dissent to share my Records ☐

I confirm that all details on this form are accurate.

Signature of Patient ☐ …… Date:……

Or

Signature on behalf of Patient: ☐ …… …… Date: …….