**BURTON LATIMER MEDICAL CENTRE**

Dr C N Spencer Dr R Child Dr S Haughney Dr A Raja Dr T Rose

Higham Road, Burton Latimer, Northamptonshire NN15 5PU

Tel: 01536 723566 Fax: 01536 420226

Child Patient and Practice Agreement

(not newborn but under 18)

To be completed if your child has been registered at another GP practice

**We accept registrations from patients living in the following areas:**

Barton Seagrave, Broughton, Burton Latimer, Cranford, Finedon, Gt. Addington, Gt. Harrowden, Irthlingborough, Isham, Lt. Addington, Lt. Harrowden, Orlingbury, Pytchley, Twywell.

**We DO NOT cover Kettering or Ise Lodge**

**Please bear the following in mind when completing the attached application forms:**

General information

1. With the exception of your signature please print your details clearly.
2. Make sure you sign and date all sections where required
3. We require **TO SEE** your child’s birth certificate / Passport to process their registration.

GMS1 Form

1. Please complete ALL sections as relevant.
2. There is a section on the back of the form for you to indicate your wishes regarding blood/organ donation on behalf of your child. Please consider completing this section carefully as it may save a life in the future. Do remember to sign it though; it is not valid unless you do!

Summary Care Record

1. Please read the information provided and, if appropriate, complete the form and return it with your completed application form.

**Without the above information we will be unable to process your Child’s application.**

UK residents and those residing in the UK for legal and settled purpose, AND living within the practice area, are entitled to register with us. Proof of eligibility will be required for asylum seekers, students and those with a visa. UK citizens who now live abroad for most of the year may not entitled to free NHS care. European Economic Area (EEA) rules apply for those residing in a member state.

Please produce the following documents:

|  |  |
| --- | --- |
| Birth Certificate / Passport seen  | Staff initials |

Please complete as much of the information below as possible. This will help with your consultations until we obtain the records from you previous GP.

Name: Master/Miss/Other (please state) ……………………………….……………..………. Date of Birth: ………………….…………

Address: ……………………………………..……………………………………………………………………………..…………………………………….……………...……

Telephone Numbers: Home…………………...…………………………………….………… Mobile …………………….......................……..…………

1st Language Spoken: ………….……………………..……….……… Height:….….…………………….…………. Weight:………………………….…..

Next of kin:…………………………………………….………… Relationship:……………………….………….. Phone:………………...…………………..

**Ethnicity** (please select one of the choices below)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **WHITE** | **MIXED** | **ASIAN OR ASIAN BRITISH** | **BLACK OR BLACK BRITISH** | **OTHER** **(Please State)** |
| British |  | White and Black Caribbean |  | Indian |  | Caribbean |  |  |
| Irish |  | White and Black African |  | Pakistani |  | African |  |
| Other White Background |  | Other Mixed Background |  | Bangladeshi |  | Other Black Background |  |
| Other Asian Background |  |

|  |  |
| --- | --- |
| Where were you born? |  |

**Past Medical History** Do you or any of your close family suffer or have suffered from any of the below?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | YOU | FAMILY MEMBER(please give relationship) | Date of Onset | Notes |
| High Blood Pressure |  |  |  |  |
| Heart Disease |  |  |  |  |
| Diabetes |  |  |  |  |
| Asthma |  |  |  |  |
| Epilepsy or fits |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Thyroid problems |  |  |  |  |
| Cancer |  |  |  |  |
| Stroke |  |  |  |  |
| Migraine |  |  |  |  |
| Mental Health problems |  |  |  |  |

|  |  |
| --- | --- |
| Do you have a carer? YES / NO | If YES please give name and contact number |

|  |  |
| --- | --- |
| Are you a carer? YES / NO | If YES please give name and relationship to you |

|  |  |
| --- | --- |
| Are you allergic to anything YES ? NO | If YES please give details on separate sheet |

**Immunisation Record** (Please give dates if known)

|  |  |
| --- | --- |
| Tetanus | BCG or Mantoux Test (for TB) |
| Diptheria | Hepatitis A |
| Polio | Typhoid |
| MMR 1st 2nd | Pheumococcal |
| Meningitis C | OTHER |

|  |  |
| --- | --- |
| Are you currently taking any medication? YES / NO | If yes please attach your repeat medication list. You will need to make an appointment with a doctor before any repeats will be issued if you are unable to provide your repeat medication list. |

Please give details of any surgical operations or serious medical problems along with the appropriate dates on a separate sheet.

Please give details of any disabilities, learning or otherwise, on a separate sheet.

**TO BE COMPLETED BY ALL PATIENTS**

If you have any questions as a result of completing this form please make an appointment to discuss them with a Practice Nurse, Nurse Prescriber or Doctor.

Thank you for taking the time to complete this document. Please read the Practice booklet which will give detail of all the services and clinics we offer.

I confirm that the information I have given is correct to the best of my knowledge.

Signed………………………………………………………………… Date…………………………………………………………….

**BURTON LATIMER MEDICAL CENTRE**

Please use this section for any additional information.

Signed………………………………………………………………… Date…………………………………………………………….

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**Applications for Children under 18**

To help us to provide optimum care whilst waiting for your medical records to arrive, please answer the following questions.

Name of child……………………………………………………………………………………… Date of Birth……………………………………………………

Address.....................................................................................................................................................................................

Parent / Carer ………………………………………………………………………………. Phone …………………………………………………………………..

Are there any other adults ( Ex partner, Grandparent etc.) who has care for this child ? YES / NO

If YES please give details

Relationship ………………………………………. Name …………………………………………………………………. Phone …………………………………..

Does the child have a Social Worker? YES / NO

If YES please give details

Name …………………………………………………………………. Contact details…………………………………………………………………………………..

Are there any other Agencies involved in their care? YES / NO

If YES please give details

Name …………………………………………………………………. Contact details…………………………………………………………………………………..

Does your child have any illnesses or allergies? YES / NO

If YES please give details

Name …………………………………………………………………. Contact details…………………………………………………………………………………..

Does your child take any medication? YES / NO

If YES please give details