Staploe Medical Centre - *NEW PATIENT INFORMATION FOR UNDER 18's*

Please complete all sections

Full Name (Mr, Mrs, Miss, Ms) ……..

Date of Birth ……..Place of Birth ……Gender……..

Contact Telephone Numbers……..

Address……

……Postcode……

Nationality……NHS Number……

First Language of child……...

Previous Address……

……Postcode……

Parent/Carer Details:-

Name ……Address……

Telephone Number (Home)……..(Mobile)……..

Relationship to Child……First Language……

Name ……Address……

Telephone Number (Home)……..(Mobile)……..

Relationship to Child……First Language……

Current Medication ……..

……

Do you have any outstanding hospital appointments that you have pending: YES / NO
If Yes please provide Reception with the information.

Ethnic Origin: Please circle which one best applies to you.

British White European Polish Baltic Estonian/Latvian/Lithuanian Romanian
Portuguese Other White Ethnic Group Black Caribbean Black African Other Black Ethnic Group
Indian Pakistani Bangladeshi Chinese Other Asian Ethnic Group Other Ethnic Group

Religion……

School (if applicable)……..

Siblings/Other Children in the Family (name, sex and date of birth)

Name……Sex M / F (please circle) Date of Birth……

Name……Sex M / F (please circle) Date of Birth……

Name……Sex M / F (please circle) Date of Birth……

Name……Sex M / F (please circle) Date of Birth……

Name……Sex M / F (please circle) Date of Birth……

Name of Previous GP……..

Name of Previous GP Practice……..

Past Medical History

Please list any illnesses or operations (There is additional space at the end of the form if needed).

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Allergies to any medication? Yes / No (Please circle as appropriate)

If yes, which type of medication? ……

Allergies to anything else? Yes / No (Please circle as appropriate)

If yes, what are you allergic to? ……

Please circle if you suffer from:

Asthma Diabetes Thyroid Disease High Blood Pressure Epilepsy Heart disease

Family History

Please circle if any of your closest family members are affected by any of these conditions

Asthma Diabetes Glaucoma Blindness Tuberculosis Infectious Diseases

Heart disease Cancer – Type of cancer (if known)……..

Others (Please specify)……

Extra Space for additional information

(Please add any other relevant information you think the Doctor should be aware of)

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FOR OFFICE USE: Received by …….. (Receptionist Initials)

Your health record and sharing of information

This page provides information about the choices you can make about sharing your health record.
Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical records.
We use a secure electronic health records systems called SystmOne. With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.
Many organisations may use SystmOne including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.
You have two choices which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.
Please contact the Patient Experience Team on 0800 279 2535 or capccg.pet@nhs.net if you have any queries.
Please note: if you have previously opted out of sharing your information via the Summary Care Record, you will still need to complete this form with your choices about sharing your health record within SystmOne.

For further details visit www.cambridgeshireandpeterboroughccg.nhs.uk

Sharing OUT – This controls whether your information recorded at this practice or service can be shared with other healthcare services.
Sharing IN – This determines whether or not this practice or service can view information in your record that has been entered by other services who are provdigin care for you, or who may provide care for you in the future.

The choices you would like to make about sharing your health record:

SHARING OUT
I would like my health record at this practice or service to be shared with other healthcare services providing care for me

Yes ☐ No ☐

SHARING IN
I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services

Yes ☐ No ☐

Signature…… Date of Birth……

Print Name…… Date……