Ramsey Health Centre

**New Patient Registration Form - Child**

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| **FOR STAFF USE ONLY (Patient Services - Please date and initial)** |
| DATE RECEIVED:  |  |
| RECEIVED BY: |  |
| NPC with nursing team offered? |  |
| NPC with GP offered (has regular medication)? |  |
| Confirmed sharing in & out preference? |  |
| Confirmed Summary Care Record preference? |  |
| Received ID if requesting Online Access? |  |
| All forms have been signed by patient? |  |

Please complete all pages in full using block capitals

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| ***Name:*** |  | ***Date of Birth:*** |  |

Welcome to Ramsey Health Centre! Please provide us with the following information so that we have an accurate record of your choices regarding treatment and information sharing.

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| **Electronic Prescribing Service (EPS)** |
| Ramsey Health Centre has a Dispensary for use by those patients who live ***more* than 1 mile from a pharmacy.**If you collect repeat prescriptions from your GP and live **less than one mile from a pharmacy** then you can choose for us to electronically send your prescription to a pharmacy that is more convenient for you. | Please select your preferred pharmacy from the list. This can be changed at any time.[ ]  Ramsey Pharmacy, **Great Whyte**[ ]  Wards of Warboys, **Warboys**[ ]  J.W. Anderson, **Somersham**[ ]  Tesco In-store Pharmacy, **Huntingdon**[ ]  Other (please provide name & Address): |

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| **Your Health Record** |
| EDSM (Enhanced Data Sharing Model) enables us, with your consent, to share your child’s medical records with those Health Professionals in the NHS who are involved in their care (for example District Nurses, Community Services teams). Only NHS staff can access shared information and being an electronic service an audit log is maintained showing when and who has accessed medical records. Do you consent to your GP Practice sharing your child’s health record with other NHS organisations who care for them? [ ]  Yes *(recommended option)* [ ]  NoDo you consent to your GP Practice viewing your child’s health record from other NHS organisations that care for them? [ ]  Yes *(recommended option)* [ ]  No |

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| **Text Message Service** |
| *It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.**We may contact you with appointment details, test results or health campaigns*  |
| ***If you do not consent to being contacted by SMS, please tick here****: [ ]  Dissent from SMS messages* |

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| **Vaccination History** |
| Please provide a printout/copy of vaccination records or the Red Book or complete below |
| **Date Given** | **Vaccination** | **Location given (i.e. GP / School – please include name of Organisation)** |
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| **Signature** |
| Signature | I confirm that the information I have provided is true to the best of my knowledge.……………………………………………………………………………………[ ]  Signed on behalf of patient (Please provide relationship to patient) |
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| Name |  | Date |  |