



OLD SWAN
HEALTH CENTRE GROUP PRACTICE
 CRYSTAL CLOSE
 LIVERPOOL
 L13 2GA

Please can you complete the enclosed patient questionnaire on behalf of your child and return it to the surgery. When completing this form please ensure that you give correct information, as we reserve the right to remove you from our practice register should you provide incorrect information.

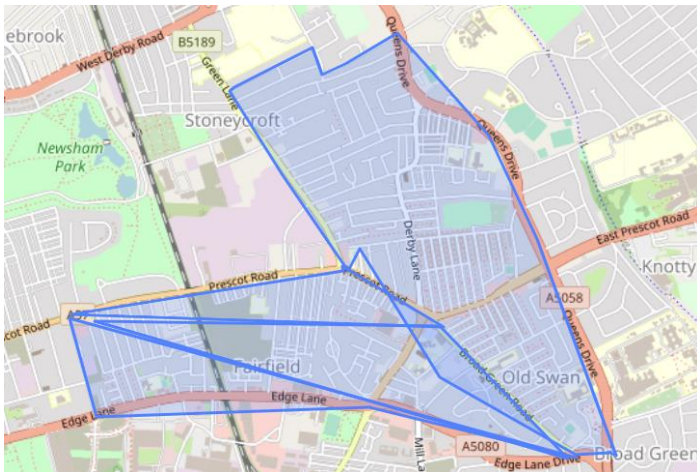
If you, the parent, are already registered at the surgery, you do not need to provide any ID to register your child. If you are registering along with your child, you will need to provide the following ID:

- Photo Identification (E.g. Passport / Driver’s License)**
- Proof of Address (E.g. Utility Bill / Bank Statement)**

Please note: we will not accept a completed registration form without the above identification.

Once the registration form has been completed and checked, you will need to book an appointment for a new patient health check with a nurse or HCA in order to complete the registration process.

Please book this appointment with reception.



(Figure 1)

Please note: we will not accept a new registration if your address is not in our **catchment area**.

Please see **Figure 1** to check if your address falls in our catchment area.

(For Admin use only)

ID TYPE	PLEASE INITIAL
GMS1 Fully Completed and Signed	
Patient Questionnaire Fully Completed	
Personal Identification Checked	
Proof of Address Checked	

This set of questions is designed to help your new doctor get to know your child and their medical problems.
 The information that you provide will be handled with the upmost confidentiality.
Thank you for taking the time to complete this questionnaire.

1. PERSONAL DETAILS OF CHILD	
Title:	
First Name(s):	
Surname:	
Date of Birth:	
Place of Birth:	
Home Address:	
Postcode:	
Home Phone N°:	
Mobile Phone N°:	
Email Address:	

2. NEXT OF KIN	
Full Name:	
Relationship to child:	
Address:	
Phone N°:	

3. CONSENT		
In keeping with the Data Protection Act 2018, we must have your consent for the following actions:		
Do you consent for the surgery to leave messages on your answer phone in regards to your child?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you consent for the surgery to contact you via SMS in regards to your child?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Signature:		Date:

3. CONSENT (CONTINUED)

A Summary Care Record is a short summary of your GP medical records. Important basic parts of your medical record, like medication and allergies, can now be shared across the NHS to other health care providers who care for you. You can also opt to share some further key information such as long-term conditions, significant medical history, or specific communications needs.

Do you consent for your child's basic medical record to be shared on the Summary Care Record?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you consent for your child's basic and additional medical record to be shared on the Summary Care Record?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
OR alternatively, do you wish to OPT OUT from your child having a Summary Care Record?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Signature:		Date:	

4. MEDICAL HISTORY OF CHILD

Has your child ever been diagnosed with the following conditions? (please give details in the box provided)

Asthma:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Diabetes:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Epilepsy:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Heart problems:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
High blood pressure:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Please detail any other significant medical history: <small>(including illness, accidents, hospital admissions or operations)</small>			
Please list any current medication:			
Please list any allergies:			

5. FAMILY HISTORY OF CHILD

Have any family or close relatives been diagnosed with the following illnesses or conditions?

Asthma:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Cancer:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Diabetes:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Epilepsy:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Heart attack:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
High blood pressure:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Stroke:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Relationship to your child:	
Please detail any other significant family history:				

6. IMMUNISATION DATA

Please check your child's red book and give dates for the following immunisations (if applicable)

IMMUNISATION	AGE							
	8 Weeks	12 Weeks	16 Weeks	1 Year	2-10 Years	3 Years & 4 months	12 to 13 Years	14 Years
6-in-1								
Rotavirus								
MenB								
Pneumococcal								
Hib/MenC								
MMR								
Flu								
4-in-1								
HPV								
3-in-1								
MenACWY								

7. ETHNICITY DATA

Please choose ONE section from 1-7 and indicate your child's ethnic category. If your child's ethnicity is not listed, then please use the boxes indicated to provide us with this information. If you do not wish to inform us of your child's ethnic category, go straight to section 8.

SECTION 1: White background

British	<input type="checkbox"/>	
Irish	<input type="checkbox"/>	
Other White background	<input type="checkbox"/>	Please specify: _____

SECTION 2: Mixed background

White and Black Caribbean	<input type="checkbox"/>	
White and Black African	<input type="checkbox"/>	
White and Asian	<input type="checkbox"/>	
Other Mixed background	<input type="checkbox"/>	Please specify: _____

SECTION 3: Asian or Asian British background

Indian	<input type="checkbox"/>	
Pakistani	<input type="checkbox"/>	
Bangladeshi	<input type="checkbox"/>	
Other Asian background	<input type="checkbox"/>	Please specify: _____

SECTION 4: Black or Black British background

Caribbean	<input type="checkbox"/>	
African	<input type="checkbox"/>	
Other Black background	<input type="checkbox"/>	Please specify: _____

SECTION 5: Chinese

Chinese	<input type="checkbox"/>	
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SECTION 6: Any other ethnic background

Any other ethnic background	<input type="checkbox"/>	Please specify: _____
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SECTION 7: Not stated

Prefer not to say	<input type="checkbox"/>	
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8. SPECIFIC NEEDS OF CHILD

Does your child have any Sensory impairment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Does your child have any physical or mental disabilities?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Does your child have any requirements to be able to access the Practice Premises?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Does your child have any other needs or requirements we may need to be aware of?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

9. LANGUAGE DATA

Please indicate your child's first language by ticking one of the boxes below.

012	English	<input type="checkbox"/>	031	Kurdish	<input type="checkbox"/>	
001	Akan (Ashanti)	<input type="checkbox"/>	032	Lingala	<input type="checkbox"/>	
002	Albanian	<input type="checkbox"/>	033	Luganda	<input type="checkbox"/>	
003	Amharic	<input type="checkbox"/>	034	Makaton (Sign Language)	<input type="checkbox"/>	
004	Arabic	<input type="checkbox"/>	035	Malayalam	<input type="checkbox"/>	
005	Bengali & Sylheti	<input type="checkbox"/>	036	Mandarin	<input type="checkbox"/>	
006	Brawa & Somali	<input type="checkbox"/>	037	Norwegian	<input type="checkbox"/>	
007	British Sign Language	<input type="checkbox"/>	038	Pashto (Pushtoo)	<input type="checkbox"/>	
008	Cantonese	<input type="checkbox"/>	039	Patois	<input type="checkbox"/>	
009	Cantonese & Vietnamese	<input type="checkbox"/>	040	Polish	<input type="checkbox"/>	
010	Creole	<input type="checkbox"/>	041	Portuguese	<input type="checkbox"/>	
011	Dutch	<input type="checkbox"/>	042	Punjabi	<input type="checkbox"/>	
013	Ethiopian	<input type="checkbox"/>	043	Russian	<input type="checkbox"/>	
014	Farsi (Persian)	<input type="checkbox"/>	044	Serbian/Croatian	<input type="checkbox"/>	
015	Finnish	<input type="checkbox"/>	045	Sinhala	<input type="checkbox"/>	
016	Flemish	<input type="checkbox"/>	046	Somali	<input type="checkbox"/>	
017	French	<input type="checkbox"/>	048	Spanish	<input type="checkbox"/>	
018	French creole	<input type="checkbox"/>	050	Swedish	<input type="checkbox"/>	
019	Gaelic	<input type="checkbox"/>	051	Sylheti	<input type="checkbox"/>	
020	German	<input type="checkbox"/>	052	Tagalog (Filipino)	<input type="checkbox"/>	
021	Greek	<input type="checkbox"/>	053	Tamil	<input type="checkbox"/>	
022	Gujarati	<input type="checkbox"/>	054	Thai	<input type="checkbox"/>	
023	Hakka	<input type="checkbox"/>	055	Tigrinya	<input type="checkbox"/>	
024	Hausa	<input type="checkbox"/>	056	Turkish	<input type="checkbox"/>	
025	Hebrew	<input type="checkbox"/>	057	Urdu	<input type="checkbox"/>	
026	Hindi	<input type="checkbox"/>	058	Vietnamese	<input type="checkbox"/>	
027	Igbo (Ibo)	<input type="checkbox"/>	059	Welsh	<input type="checkbox"/>	
028	Italian	<input type="checkbox"/>	060	Yoruba	<input type="checkbox"/>	
029	Japanese	<input type="checkbox"/>	200	Other	<input type="checkbox"/>	
030	Korean	<input type="checkbox"/>	Please specify:			
Does your child require an interpreter?					YES <input type="checkbox"/>	NO <input type="checkbox"/>

10. RELIGION DATA

How would you describe your child's religion?

A1	Baha'i	<input type="checkbox"/>	G1	Muslim	<input type="checkbox"/>
B1	Buddhist	<input type="checkbox"/>	H1	Pagan	<input type="checkbox"/>
C1	Christian	<input type="checkbox"/>	I1	Sikh	<input type="checkbox"/>
C22	Church of England	<input type="checkbox"/>	J1	Zoroastrian	<input type="checkbox"/>
C44	Jehovah's Witness	<input type="checkbox"/>	L2	Not Religious	<input type="checkbox"/>
C67	Roman Catholic	<input type="checkbox"/>	K20	Other	<input type="checkbox"/>
D1	Hindu	<input type="checkbox"/>	Please specify:		
E1	Jain	<input type="checkbox"/>	M1	I do not wish to disclose my child's religion	<input type="checkbox"/>
F1	Jewish	<input type="checkbox"/>			