

**Partington Family Practice, Partington Health Centre, Central Road, Partington, M31 4FY**

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**NEW PATIENT REGISTRATION FORM – Under 16’s**

**About You**

Title: ……. Surname: …………………………………… Forename(s): ………………………………………….

Do you have a preferred name (eg Jennie vs Jennifer)? .................................................................................

Previous Surname: ………………………………………. Date of Birth: ………………………...........................

Gender: ……………………………………………………. NHS Number: ……………………………..…………..

Previous GP Practice Address: ….…………………………………………………………………………………….

**Contact Information**

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

Post Code: ………………………………………………… Telephone: …………………………………………….

Mobile: ……………………………………………………... Email: …………………………………………………..

**Ethnicity**

Having information about patients’ ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients’ needs. If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

|  |  |
| --- | --- |
| British or mixed British |[ ]  Pakistani |[ ]
| Irish |[ ]  Bangladeshi |[ ]
| African |[ ]  Chinese |[ ]
| Caribbean |[ ]  Other (please state): |[ ]
| Indian |[ ]   |  |

**Religious Affiliation**

Do you have a religious affiliation (please give details if so)? ..........................................................................

**Place of Birth**

In which Country and City were you born? .......................................................................................................

**Main Language**

Which is your main language? ..........................................................................................................................

Do you speak English? .....................................................................................................................................

**Next of Kin (For Emergency Contact)**

Surname: …………………………………………………... Forename(s): ………………………………………….

Gender: ……………………………………………………. Relationship to you: …………………………………..

Telephone: ………………………………………………... Mobile: ………………………………………………….

Please select your preferred choice of contact: **Text** [ ]  **Phone** [ ]  **Email** [ ]  **Post** [ ]

**Record Sharing**

Partington Family Practice would like to hold, process and share your personal and medical records, manually and electronically, as outlined below

**EMIS Sharing**

Locally for the purposes of the Local Shared Electronic Record (CHIE) and the OOH Hub for my direct health care.

**Opt In** [ ]  **Opt Out** [ ]

**Summary Care Record**

Nationally for the purposes of National Shared Electronic Record (SCR) for my direct health care.

**Opt In** [ ]  **Opt Out** [ ]

**Research**

Nationally for the purposes of improving and planning the health and care of current and future generations (indirect health care)

**Opt In** [ ]  **Opt Out** [ ]

**Electronic Prescribing Service (EPS)**

Please nominate a pharmacy below for all your regular prescriptions to be sent for collection.

Nominated pharmacy: ………………………………………………………………………………………………….

Postcode: ………………………………………………………………………………………………………………...

If you know you need a separate appliance pharmacy please nominate below:

Nominated appliance pharmacy: ……………………………………………………………………………………...

Postcode: ………………………………………………………………………………………………………………...

**Donation Wishes**

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.

If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit: <https://www.organdonation.nhs.uk/register-your-decision/do-not-donate/>

**Disabilities / Accessible Information Standards**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs? **Yes** [ ]  **No** [ ]

If yes,please state your needs: ……………………………………………………………………………………….

……………………………………………………………………………………………………………………………..

Are you blind/partially sighted? **Blind** [ ]  **Partially sighted** [ ]

Do you have significant problems with your hearing? **Deafness** [ ]  **Hearing difficulty** [ ]

Do you have significant mobility issues? **Yes** [ ]  **No** [ ]

If yes, are you housebound? **Yes** [ ]  **No** [ ]

*(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)*

**Medications**

Please provide a list of repeat medications you take: ………………………………………………………………

……………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………..

**Allergies**

Please list any drug or food allergies that you have: ……..…………………………………………………………

……………………………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………………..

**Consent**

**I consent that the information given is true to the best of my knowledge.**

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

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Print name: ………………………………………………………………………………………………………………