GRAFTON
MEDICAL PARTNERS

Child New Patient Check (0 – 16 years)

(Fill Form In **Block** Letter)

DATE: _____ **TITLE:**_____

(Name as per passport)

FORENAME(S): **MIDDLENAME(S):** **SURNAME(S):**

_____ _____ _____

ADDRESS:

_____

DATE OF BIRTH: **NHS NO:**

_____

_____

(DD/MM/YYYY) **(As per red book if born in UK)**

FULL NAME OF PARENT/CARER (1):

_____

FULL NAME OF PARENT/CARER (2):

_____

PARENT/CARER CONTACT No (1): **PARENT/CARER CONTACT No (2):**

_____ _____

EMAIL ADDRESS:

_____

MAIN LANGUAGE SPOKEN HOME?

_____

DO YOU REQUIRE AN INTERPRETER?

(CIRCLE YES IF REQUIRED)

YES | NO

Please provide a copy of your passport if born outside of the UK

Name of School: _____

Address of School: _____

_____

Parent/Guardian section:

Height of your child: _____ (cms) Weight of your child: _____ (kgs)

Has your child ever had any serious illnesses/diseases/operations? Yes/No
If yes, what?
_____

Does your child take any medications: Yes/No
If yes, what?
_____

Is your child allergic to any medications: Yes/No
If yes, what?
_____

Is your child allergic to anything else? Yes/No
If yes, what?
_____

Vaccination Dates – (Please refer to the red book if born in UK)

Name of Vaccination	**Date**
1st Diphtheria, tetanus, whooping cough, HIB, polio, 1st pneumonia (prevenar)	
2nd Diptheria, tetanus, whooping cough, HIB, polio, 1st meningitis C	
3rd Diptheria, tetanus, whooping cough, HIB, polio 2nd Meningitis 2nd Pneumonia	
HIB/Meningitis C	
1st MMR and pneumonia	
1nd MMR	
Pre School Booster - Diptheria, tetanus, whooping cough, polio	
BCG	

Ethnicity Questionnaire

What is your ethnicity? (Please tick a box to complete the registration)
Please choose one section A to E and then tick the appropriate box to indicate your cultural background:

A White	(9i0) British	☐
	(9i1) Irish	☐
	(9i2) Any other white background	☐
B Mixed	(9i3) White and black Caribbean	☐
	(9i4) White and black African	☐
	(9i5) White and Asian	☐
	(9i6) Any other mixed background	☐
C Asian or Asian British	(9i7) Indian	☐
	(9i8) Pakistani	☐
	(9i9) Bangladeshi	☐
	(9iA) Any other Asian background	☐
D Black or Black British	(9iB) Caribbean	☐
	(9iC) African	☐
	(9iD) Any other Black background	☐
E Other Ethnic groups	(9iE) Chinese	☐
	(9iF) other ethnic category	☐
	(9iG) Not stated	☐

ACCESSIBLE INFORMATION STANDARD

Please note that all of our incoming and outgoing calls are recorded for training and auditing purposes.

PRINT NAME: _____

SIGNED: _____

DATED: _____

ELECTRONIC PRESCRIBING SERVICE (EPS)

The Electronic Prescription Service (EPS) is an NHS service. It gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from.

Repeat of antidepressants?
Please note it is not our general policy to prescribe antidepressants on repeat prescription. We are aware that some practices do this, but we feel this type of medication should be reviewed monthly and will prescribe on an acute basis. Please do not request medication, which has not been added to repeat medication but make an appointment with one of our clinicians 10 days before running out of medication

What does this mean for you?
If you collect your repeat prescriptions from your GP, you will not have to visit your GP practice to pick up your paper prescription. Instead, your GP will send it electronically to the place you choose, saving you time. Your medicines can be collected from a pharmacy near to where you live, work or shop. You may not have to wait as long at the pharmacy as there will be time for your repeat prescriptions to be ready before you arrive.

How to order repeat prescriptions?
Please contact your nominated pharmacy at least 7 days before the end of your medications, giving enough of time for your pharmacy and the GP surgery to arrange a repeat prescription at the pharmacy.

How can you use EPS?
You need to choose a place for your GP practice to electronically send your prescription to a pharmacy.. This is called nomination.

Can I change my nomination?
Yes, you can. Let us know which is the new pharmacy you want to nominate.

Is EPS reliable, secure, and confidential?
Yes. Your electronic prescription will be seen by the same people in GP practices, pharmacies and NHS prescription payment and fraud agencies that see your paper prescription now.

The following local pharmacies offer EPS. Tick to nominate your preferred pharmacy or, alternatively, provide the name and address of an alternative dispenser here:

_____

Barrons Chemist	158A Tooting High Street, Tooting SW17 0RT	☐
Lords Pharmacy	98 Tooting High Street, Tooting SW17 0RR	☐
Boots	59-61 Mitcham Road, Tooting SW17 9PB	☐
Auckland Rogers	892 Garratt Lane, Tooting SW17 0NB	☐
Pearl Chemist	134-136 Mitcham Road, Tooting SW17 9NH	☐
Barkers Chemist	223 Upper Tooting Road, Tooting SW17 7TG	☐
Cospharm	281-283 Mitcham Road, Tooting SW17 9JQ	☐
AP Chemist	129 High Street, Colliers Wood SW19 2HR	☐
Tooting Pharmacy Practice	175 Upper Tooting Road, Tooting SW17 7TJ	☐
Day Lewis	145 Franciscan Road, Tooting SW17 8DS	☐
Boots	Unit 9, The Tandem Centre, Colliers Wood SW19 2TY	☐
Nettles Pharmacy	18 Upper Tooting Road, London SW17 7PG	☐
Trinity Pharmacy	278-280 Balham High Road, Balham SW17 7AL	☐
C Bradbury	86 Moyser Road, Tooting SW16 6SQ	☐
Fairoak Pharmacy	270 Mitcham Lane, Streatham SW16 6NU	☐
Day Lewis	256 Balham High Road, London SW17 7AW	☐

Other (Name & Address) ☐

APPLICATION FOR ONLINE ACCESS

(Fill Form in Block Letters)

DATE: _____ **TITLE: _____**

FORENAME(S): **MIDDLENAME(S):**

SURNAME(S):

ADDRESS:

DATE OF BIRTH: **TELEPHONE NUMBER:**

(DD/MM/YYYY)

EMAIL ADDRESS:

THIS IS A REQUEST FOR ACCESS:

TO BOOK APPOINTMENTS, REQUEST REPEAT PRISCRIPTIONS AND ACCESS MEDICAL RECORDS

I wish to access my medical record online and understand and agree with each statement:

I will be responsible for the security of the information that I see or download

If I choose to share my information with anyone else, this is at my own risk.

I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement

ON BEHALF OF PATIENTS (BELOW 16 YEARS) ☐:

NAME:

SIGNED:

IT IS ESSENTIAL THAT YOU PROVIDE PHOTO ID AND PROOF OF ADDRESS TO ACCESS THIS FACILITY

FOR PRACTICE USE ONLY:

Documents seen as Proof of ID:

Documents seen as Proof of Address:

(Documents accepted: Passport, Driving license, Utility Bills, Bank Statement, Tenancy Agreement)

IDENTITY VERIFIED BY (STAFF NAME): _____ **STAFF INITIAL:** _____ **DATED:**

Your emergency care summary

Summary Care Record

A Summary Care Record will not contain detailed information about your medical history, but will only contain important health information, such as:

- whether you're taking any prescription medication
- whether you have any allergies
- whether you've previously had a bad reaction to any medication

The only people who can see the information will be healthcare staff directly involved in your care who have a special smartcard and access number (like a chip-and-pin credit card).
The benefits are: For example, a person who lives in London is on holiday in Brighton. One evening, they're knocked unconscious in a car accident and taken to an accident and emergency (A&E) department. Under the current system of storing health records, it would be difficult for A&R staff to find out whether there are any important factors to consider when treating the person (such as any serious allergies to medications), especially as their GP surgery is likely to be closed. If healthcare staff cannot get the relevant health information quickly, some patients may be at risk.

Please **tick ONE** option only:

I **consent** to: Medication, allergies & adverse reactions being held on my SCR ☐

I **consent** to: Medication, allergies, adverse reactions & additional information being held on my SCR ☐

I **dissent** from a SCR being held on my behalf ☐

For Official Use Only

Registration Check list	Tick checked

Check postcode (If patient lives in catchment area)	

GSM form	Name and DOB	
	Town & Country of birth	
	NHS No (If had previous surgery or as per red book)	
	Previous address in the UK	
	Previous GP in the UK	
	Date of entry in UK (If no pervious GP)	
	Signature of parent/carer of the patient on GSM form	

Questionnaire Form	Check if questionnaire is completed	
	Check if pharmacy is nominated(Only one)	

Online Form	Check email address is readable	
	Write the documents seen for proof ID and address	
	Staff name and signature	

SCR Form	Check expressed consent/dissent ticket	

Staff Name: _____

Staff initials: _____

Date: _____