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| photo | |  | | --- | | Dr. James Ogle  Dr. Reema Parwaiz  Dr. Zan Parwaiz  Dr. Paul Parwaiz | | |  | | --- | | icon  0116 2394960   icon [www.ratbysurgery.nhs.uk/](https://www.ratbysurgery.nhs.uk/)  icon  [Ratby.MedicalCentre@nhs.net](mailto:Ratby.MedicalCentre@nhs.net)  icon  [1A Desford Lane, Raby, Leicestershire, LE6 0LE](https://maps.google.com/?q=Ratby%20Medical%20Centre,%201A%20Desford%20Lane,%20Ratby,%20Leicestershire,%20LE6%200LE) | | |

Thank you for applying to join Ratby Medical Centre. We would like to gather some information about your child and ask that you fill in the following questionnaire. You don’t have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

**You MUST sign the form on the final page to confirm all the details given are correct.**

ALL INFORMATION GIVEN TO US WILL BE CONFIDENTIAL AND USED ONLY IN ACORDANCE WITH STATUTORY REGULATIONS e.g. Data Protection Act / GDPR etc

If you need any support in completing this form, please ask at the reception. If you have a disability, which means you need information in a different way please contact the surgery and fill in an Accessibility Contact Form.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Fields marked with an Asterix (\*) are mandatory.

**PLEASE NOTE: IF YOU ARE REGISTERING AND LIVE AT AN ADDRESS OUTSIDE OUR CATCHMENT AREA**

**THE DOCTORS WILL NOT BE ABLE TO PROVIDE HOME VISITS.**

**IF YOU ALSO DO NOT ATTEND FOR THE REQUIRED MEDICATION CHECKS OR REQUIRED MONITORING, WE RESERVE THE RIGHT TO ASK YOU TO REGISTER WITH A LOCAL PRACTICE UNDER BREAKDOWN OF DOCTOR-PATIENT RELATIONSHIP\***

Please tick to confirm you have read this.

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| \*Title | \*First names |  | \* Any previous surname(s) |
| \*Surname | |  | Town and country of birth |
| \*What is your child’s gender identity?  Male Female  Non-binary Prefer not to say  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Do your child identify as transgender?  Yes No  Prefer not to say  \*What sex was your child assigned at birth?  Male Female  Intersex Prefer not to say | |  | What are your child’s preferred pronouns?  He / him / his  She / her / hers  They / them / theirs  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*NHS No.  (if known) |
| \*Date of Birth | |  | \*Home address |
| \*Home telephone No. | |  |  |
| \*Mobile No. (if you have one) | |  | Email address:   |  | | --- | | \*Main spoken languages | | **English** | | **Other** (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Interpreter required? | |
| \*School Name / Nursery Name:  Home schooled | |
| |  | | --- | | Would you agree to the Practice sending you text reminders? \* Yes No  If YES you MUST advise the practice if your mobile number changes or it is no longer in your possession  I consent to the practice contacting me by text message and / or email for the purpose of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time. Text messages are generated using secure facilities, but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however, the practice will not transmit information which would enable an individual patient to be identified.    Answering machine messages\*  Yes  No |  |  | | --- | | Name of next of kin:  Relationship to your child:  Next of kin telephone number(s)  Next of kin address (if different to above) |  |  | | --- | | Do you or your child have any additional communication needs? Yes No  Please state your requirements and whether they are for you or your child……………………..………………………………  ……………………………………………………………………………………………………………………………………….………………………………..  We have a hearing loop – please ask at reception for details |  |  | | --- | | Previous address and doctors details…………………………………………………………………………………………………………  ……………………………………………..……………………………………………………………………………………………………………………… |  |  | | --- | | **\*** Weight**……………………………… \***Height**…………………………………..** |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Additional details about you**  \*What is your ethnic group? (Choose an option that best describe your ethnic group or background) | | | | | | | | **White**  **Black**  **Asian**  **Mixed**  **Other** |  | English/Welsh/Scottish  Caribbean  Indian  White + Black  *Please specify*: |  | Northern Irish  African  Pakistani  White + African |  | Irish  Other  Chinese  White  +Asian | | | | |

**If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child**

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| Who has the legal responsibility for the child? |  | Who can consent for the medical treatment for the child?  You as the legal parent or guardian  **Other** (please specify)  ...………………………………………………………  Name:……………………………………………….  Relationship to the child…………………….  Contact number………………………………… |
| You as the legal parent or guardian |  |
| **Other** (please specify)  ...………………………………………………………  Name:………………………………………………  Contact number………………………………..  Evidence of parental responsibility (birth  certificate / social care  information)……………………………………..  ……………………………………………………….. |  |

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| **Looked after Children**  Is this child a looked after child?  Yes  No  If Yes, under what arrangements:  Section 20-Voluntary Care  Interim Care Order  Full Care Order  Child arrangement order/Residence Order  Special Guardianship order  Placed for adoption  \*Private arrangement/Private Fostering/informal arrangement - please note you have a duty to notify social care of this arrangement  \*Private fostering is an arrangement that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with the people stated below:   |  |  | | --- | --- | | *Private Fostering* ***includes*** *a child living with:* | *Private Fostering* ***does not include*** *a child living with:* | | * godparents * great-grandparents * great aunts or uncles * family friends * step parents where a couple isn't married or in a civil partnership * cousins * a host family which is caring for a child from overseas while they are in education here | * brothers * sisters * grandparents * aunts * uncles * step parents where a couple is married or in a civil partnership * mother * father * children and young people who are being looked-after by the Local Authority | |

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| Is your child a young carer? Yes No  If yes, do you look after someone who is a patient of Ratby Medical Centre? Yes No  Don’t know  If yes, what is their name?  Are they a: Relative Friend Neighbour |

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| Medical details (Please list any medications including contraception): |

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| \*Is your child you allergic to any medicines?  Yes  No (if yes please specify below) |

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| Does your child have a social worker? Yes  No  If yes, name of Social worker ……………………………………………………………………………………………………..  Are there any other agencies involved in their care? Yes  No  If yes, contact details ………………………………………………………………………………………………………………….. |

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| **Immunisations:**  **If are from abroad, please** **provide a copy of your child’s immunisation history.**  Is your child up to date with their immunisations? Yes  No  If No please specify why:  ……………………………………………………………………………………………………………………………………………………………………. |

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| **You can register for online services**. This would give you access to booking appointments, ordering repeat prescriptions, viewing any blood test results etc. Would you like this? \*Yes No  If you wish to access your medical record online please read and tick the following statements to show you agree with each statement:   1. I will be responsible for the security of my login and password. 2. I will be responsible for the security of the information I see and download. 3. If I choose to share my information with anyone else, this is at my own risk. 4. I will contact the practice as soon as possible if I suspect that my account has been accessed by   someone without my agreement.   1. If I see information in my record that is not about me, or is inaccurate, I will log out immediately   and contact the practice as soon as possible, |

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| **Please record any additional information about you that you think is important for us to know**  (Additional information includes: Social worker involved with your family; legal parental responsibilities of minor under 16 years old; applicant is in foster care or is adopted; if you are from overseas and claiming asylum or are a refugee) |



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| **\*Signed \*Date** (dd/mm/yyyy) **/ /**  **Signed on behalf of patient** (*if applicable*) **Full Name:**  (Minors under 16 years old, adults lacking capacity) |
| **Relationship:** |

**Thank you for providing this information. We look forward to providing you with high standard of care in a friendly and professional manner.**