**Salisbury Medical Centre – Child New Patient Form**

*I.E. Under 16*

**Name: DOB:**

**Name of Parent/Guardian**

**Completing form:**  **Relationship to Patient:**

**Have you been registered at Salisbury Medical Centre before? YES NO**

**If YES, what was your reason for leaving?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason you left your most recent registered Practice?**

*(Please tick most appropriate response)*

**□ You Have Not Been Registered with a UK Practice □ Immediate Removal for Violent Behaviour/ Paragraph 21**

**□ Moved Out of Their Catchment** *(You* ***must*** *inform the Practice if this is the case)*

**□ Family are Registered at Salisbury □ Eight Day Removal for GP/Patient Breakdown**

**□ Unhappy with Service □ Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the above named, currently or ever, had any social work involvement? YES NO**

If YES:

Please provide the name and contact details of the lead social worker.

If you no longer have involvement, please give an approximate date when this ended and the name and contact details of who the lead social worker was at the time.

**Does the above require use of an interpreter at appointments? YES NO**

If YES, Please specify what require i.e. BSL/language **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION**

Please provide the Practice with written confirmation of your medications from your recent Practice. Medication cannot be prescribed without this confirmation. This can be handed in or emailed ([gp.z00086@gp.hscni.net](mailto:gp.z00086@gp.hscni.net)).

**Does your child have any allergies? If so, please state drug name(s) and the reaction you have.**

**Which local chemist do you wish to pick up your prescription?**

***Please state which chemist***

*Please ensure the chemist you choose has a collection service with the Practice. Ask reception if you are unsure. If you elect a pharmacy to collect your prescriptions all your orders must go there unless it is an urgent acute item such as an antibiotic.*

**IMMUNISATIONS**

Please detail any immunisations your child has had.

|  |  |  |
| --- | --- | --- |
| **AGE** | **VACCINATIONS** | **DATE GIVEN** |
| 8 WEEKS | Diptheria/Tetanus/Pertusis/Polio/Hib/Hep B |  |
|  | Men B |  |
|  | Rotavirus |  |
| 12 weeks | Diptheria/Tetanus/Pertusis/Polio/Hib/Hep B |  |
|  | Pneumococcal |  |
|  | Rotavirus |  |
| 16 weeks | Diptheria/Tetanus/pertussis/Polio/Hib/Hep B |  |
|  | Men B |  |
| 1 Year | MMR |  |
|  | Hib/Men C |  |
|  | Pneumococcal |  |
|  | Men B |  |
| Pre-School | Diptheria/Tetanus/Pertusis/Polio |  |
|  | MMR |  |
| Other |  |  |

**STAFF USE ONLY**

* Ensure all details completed in form
  + Enter all details into patients journal upon registration
* Read code interpreter #9NU
  + Return
  + Go down until correct language
* Read code social if there is work involvement #13G4
  + Free hand type contact details
* Read code asylum seeker/refugee/Ukrainian National #13ZN/#13ZB/#13di
  + Let Jacquie know
* If removed for violent behaviour or GP/Patient breakdown let Rebecca know