11 – 16 YEAR OLD REGISTRATION FORM

Southwood Practice

Surname: …… ***Forenames:*** ……

NHS Number: .....

Mother's name: …… ***Father's name:*** ……
Do they have parental responsibility ❑ Do they have parental responsibility ❑

Mother's Telephone Number:..... Father's Telephone Number:.....

Have you been registered with Southwood Practice before? ❑ NO ❑ Yes -first registered in….....

Sex: Male Female (*circle*) ***Date of Birth:*** …….

Address: ……

Address of parent with responsibility who may not be living with child:.....

……..

Ethnic Origin: ……. ***Place of Birth:*** ……
eg White British, Indian, Chinese, White European

First Language: …… ***Second Language:*** ……
If you do not wish your language status to be recorded in your medical records please tick this box ❑
If you need an interpreter for your any appointments please tick ❑

Home Phone No: ……..…

Mobile Phone No:…..... (***Please indicate if using parents mobile***)

Please indicate if you would like to opt out of receiving information and appointment reminders via text ❑ email ❑

Next of Kin – Name and Contact No: ……

Child's Height: …… ***Child's Weight:*** ……

Smoking History
Do they smoke? No ☐ Yes ☐ How many per day? ……

NOTE 11-16 year olds do not have access to on-line services, in order to maintain the confidentially of the patients medical record.
GP Practices will upload some your data to NHS departments as part of its NHS contract to those mentioned below; if you **do not** want to have your medical information uploaded please indicate below (further information is found on our website):
Hampshire Health Record ☐ HSCIC ☐ Summary Care Record ☐

Please tick if you wish to **opt IN** to receiving appointment reminders via text email

Have you nominated a pharmacy to receive your electronic prescriptions? Yes No

If YES you will need to notify your nominated pharmacy that you have moved.

Parent's Signature: ……
Print Name: ……
Date: ……..

Office Use Only: Note what type of ID you see – Over 16s only
ID seen: Photographic ……..
Non-photographic …….
EPS checked……...

Received by (staff initials)…….

Opt In/Out Patient Choice Form

For more information on data sharing please see our web site under GDPR and also www.nhsdatasharing.info.

Please tick the following if you wish to **OPT-IN**

To receive SMS text reminders for appointments and/or health promotion information (from Southwood Practice only) ☐

To receive email health promotion information (from Southwood Practice only) ☐

IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORD (Please read carefully)
The NHS shares data from your medical record in a number of ways. You have the right to control how your personal information is used and who has access to it. You can opt out of this data sharing by completing the form below. We will then add relevant coding to your record to stop the extraction and processing.

I DO NOT wish for any information to be extracted and uploaded from my GP record for the following purposes: (Please tick those below where you wish to OPT-OUT).

National Data Opt-Out ☐
Please Opt me out of this section *Office use: Code - 9Nu0 Dissent from secondary use and NSOO (9Nu4 no longer valid from 25/5/18)*

The Summary Care Record ☐
Please Opt me out of this section *Office use: Code - 9Ndo express dissent from SCR upload*

Clinical Data Repositories/Warehouses ☐
(e.g. The Hampshire Health Record, Connected Care, The Manchester Care Record, The Stockport Health and Care Record, The Salford Integrated Record, The Cheshire Care Record, The North Staffs/Stoke-On Trent Shared Record)
Please Opt me out of this section *Office use: Code - 9Nd1 no consent for electronic record sharing*

Risk Stratification (a secondary use of your information) ☐
Please Opt me out of this section *Office use: Code- 9Nu0 Dissent from secondary use (as appropriate)*

Please ensure that no further information is uploaded about me. I understand that I can opt back in to any or all of these databases at any time in the future by informing the Practice in writing.

ONLY SIGN HERE IF YOU HAVE TICKED ANY OR ALL OF THE BOXES ABOVE

Patient Name: _____

Parent name: _____

Parent Signature: _____