Castle Medical Group
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Newborn Registration Form CMG

PLEASE ALLOW AT LEAST 7 WORKING DAYS FOR THE REGISTRATION TEAM TO DEAL WITH YOUR REGISTRATION BEFORE YOU TRY TO BOOK AN APPOINTMENT.

Thank you for applying to join Castle Medical Group. We would like to gather some information about you 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.

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s) (if applicable)	*Date of Birth
*☐ Male ☐ Female	***NHS No** ☐☐☐ ☐☐☐ ☐☐☐☐
Town and country of birth	*Home address
*Home telephone No	
Work telephone No	*Postcode
*Mobile No (if you have one)	Email address

Additional details about you

What is your ethnic group?

White	☐ British	☐ Irish	☐ Other White (please specify):
Black	☐ Caribbean	☐ African	☐ Other Black (please specify):
Asian	☐ Indian	☐ Pakistani	☐ Other Asian (please specify):
Mixed	☐ White & Black Caribbean	☐ White & African	☐ White & Asian

Next of kin

Name of next of kin	Relationship to you
Next of kin telephone number(s)	Next of kin address (if different to above)

Medication

We have the facility to prescribe your medication electronically to a nominated pharmacy, i.e. we do not issue you with a paper prescription and the 48 hour turnaround is the same.

The following are the local pharmacies :– Boots ☐ Dean & Smedley ☐ Ashby Pharmacy ☐ Tesco Pharmacy ☐

Please tick your preferred pharmacy

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

Do you have family history of any of the following?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who

Data Sharing

Summary Care Record (SCR)
The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk**

Patients Summary Care Record (SCR) Consent Preference:
- Express consent for medication, allergies, adverse reactions and additional information ☐Yes ☐ No
-Express dissent – patient does not want a Summary Care Record
☐ Yes ☐ No

NHS Organ Donor Registration
"I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death". Please tick the boxes that apply.

☐ Any of my organs and tissue or…
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation ……. Date……/……./……..
For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

NHS Blood Donor Registration
"I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood."
Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register ……. Date……/……./…….

SystmOnline

Once your application to join our practice has been accepted you'll be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **SystmOnline**.
Once you are a fully registered patient of our practice you can obtain a User ID and Password from Reception.

***Signed**

***Date / / /**

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE: _____** **ADDRESS ID** ☐ **TYPE: _____**
(Aged 16 and over only)

Change of Name Deed Poll ☐ **or Marriage Certificate** ☐

Overseas Patients:
Non UK EHIC ☐ **or PRC** ☐ **or S1 Forms** ☐