



# PORTREE MEDICAL CENTRE

## HOW TO REGISTER WITH PORTREE MEDICAL CENTRE

*6 years old to 14 years old*

Please complete the enclosed forms:

*'Application to Register Permanently with a General Medical Practice'*

*'New Patient Questionnaire'*

All boxes marked with \* must be completed

### CHECKLIST

- Have you completed and signed the *'Application to Register Permanently with a General Medical Practice'* form?
- Have you completed the *'New Patient Questionnaire'*?
- Have you indicated your consent/withheld consent to sharing contact details and signed in the appropriate box?
- Are you aware that you need to tell us if you change mobile number or contact details?
- If you take regular medication, you need to make an appointment with a GP before you can reorder it.



Please complete all sections as fully as possible

Has your child ever been seen at Portree Medical Centre before? Yes / No

Name .....	Date of Birth .....
Birth or Other Surname .....	Preferred Calling Name.....

Miss  Ms  Master  Other

Do you give permission for contact details to be shared, when necessary, with others involved in your child's care?	Yes / No
Signature .....	Date .....

Next of kin (name, address and telephone number) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship to child \_\_\_\_\_

**Ethnicity** – We hope that you do not mind completing this section. There may be cultural issues in relation to healthcare that we should be aware of.

I would describe my child's ethnicity as:			
White Scottish <input type="checkbox"/>	Indian <input type="checkbox"/>	African <input type="checkbox"/>	Other <input type="checkbox"/>
White British <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Black or Black Scottish <input type="checkbox"/>	
White Irish <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other Asian <input type="checkbox"/>	
Other White <input type="checkbox"/>	Chinese <input type="checkbox"/>	Any mixed background <input type="checkbox"/>	
	Caribbean <input type="checkbox"/>	Other ethnic group <input type="checkbox"/>	
Country of Birth:			
UK <input type="checkbox"/>	Other EEC <input type="checkbox"/>	Other (Please specify) .....	

**Personal Health History**

Heart Condition	Yes / No	Other	
Diabetes	Yes / No	Other	
Asthma	Yes / No		

Have they had any infectious disease? Yes /No	
Please list any below	Date
.....	.....
.....	.....

Please tell us about current conditions, past illnesses, accidents, operations or other hospital admissions including, if possible, a date or what age your child was.	
Illness/condition/accident/operation/admission etc.	Date/age
.....	.....
.....	.....
.....	.....

**Family History**

Do either of your child's parents have or have had any of the following:

Heart disease	Yes / No	Mum / Dad
Diabetes	Yes / No	Mum / Dad
Stroke/CVA	Yes / No	Mum / Dad
Asthma	Yes / No	Mum / Dad
High blood pressure	Yes / No	Mum / Dad

**Medication**

Please list all medication that your child takes. Please include any medication which is bought from the chemist.			
Name	Dose	Name	Dose
.....	.....	.....	.....
.....	.....	.....	.....
Does your child have any allergies? Yes / No			
Which, if any? .....			

**Being a Carer and Being Cared For**

<b>Being a Carer</b>	
Does your child care for someone?	Yes / No
Do we have your permission to include your child's name on our carers register and to undertake periodic review of your child's well-being and support that they may need?	Yes / No
What is your child's relationship with the person being cared for? .....	
Is the person registered with this practice?	Yes / No
<b>Under the Data Protection Act 2018/General Data Protection Regulation (GDPR), we also need the permission of the person being cared for before recording their name.</b>	
Please advise us of the name and address of the person being cared for:	
NAME .....	
ADDRESS .....	
<b>Being Cared For</b>	
Does your child have a carer?	Yes / No
Do we have your permission to record in your child's medical records that they have a carer?	Yes / No
What is their relationship with your child's carer? .....	
Is this carer registered with this practice?	Yes / No
<b>Under the Data Protection Act 2018/General Data Protection Regulation (GDPR), we also need the permission of the carer before recording their name in your child's medical record.</b>	
Please advise us of the name and address of the carer below:	
NAME .....	
ADDRESS .....	

**We will not discuss any aspect of your child's medical treatment or care with their carer unless we have your permission to do so.**

Thank you for taking the time to fill in this questionnaire.

Portree Medical Centre, Fancy Hill, Portree, IV51 9BZ  
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