Chilwell Valley and Meadows Practice

The Valley Surgery
81 Bramcote Lane
Chilwell
Nottingham NG9 4ET
Telephone: 0115 9430530
Fax: 0115 9431958

Chilwell Meadows Surgery
Ranson Road
Chilwell
Nottingham NG9 6DX
Telephone: 0115 9462767
Fax: 0115 9462977

0 – 5 YEARS QUESTIONNAIRE

NAME			
DATE OF BIRTH			
Names of people with parental responsibility			
What is your main language spoken at home?			
What immunisations has your child had? (please tick appropriate boxes and give dates if possible)			
	1st date given	2nd date given	3rd date given
Diphtheria & Tetanus, Polio, Whooping Cough, HIB			
Prevenar			
Rotarix Oral			
Meningitis C			
HIB/Men C			
MMR (measles,mumps & rubella)			
Pre school booster			
Has your child had any illnesses/operations?			
Is your child on any medicine/creams/inhalers?			
Has your child had any severe reaction to any previous vaccines? (If so, which and when)			

Any other relevant medical history?	
I would/would not like my ethnic group to be recorded on my records (delete as appropriate)	Please record it as:

Has your child had any problems you would like to discuss? Please feel free to
make an appointment with the DOCTOR or HEALTH VISITOR if you wish.

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date

Please see overleaf re: Organ donation

Family doctor services registration

GMS1

NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHSBlood 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**

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services
☐ For the provision of contraceptive services
☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Printed by THE ASTRON GROUP, 03/02, J0160463