**NEW PATIENT HEALTH QUESTIONNAIRE**

Please speak to a member of our team if you would like assistance when completing this form or require the information in a format other than our standard print.

**ALL ITEMS ASTERISKED \* MUST BE COMPLETED**

**PLEASE WRITE CLEARLY, IN BLACK INK AND USE CAPITALS**

**\*TITLE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * **DR**
 | * **MR**
 | * **MRS**
 | * **MISS**
 | * **MS**
 | * **MX**
 |

**\*GENDER:**

|  |  |  |
| --- | --- | --- |
| * **MALE**
 | * **FEMALE**
 |  |

Downend Health Group follows the PCSE electronic registration process and their pre-determined questions. This process limits the practice on the types of gender identity options we can offer. For the purpose of this registration, it is important that patients inform us of their birth gender so that we can arrange the smooth transfer of medical records from your previous practice.

Please see note at the end of this registration form for further information relating to preferred pronouns and gender identity.

**\*SURNAME/FAMILY NAME: PREVIOUS SURNAME: \*FIRST NAME(s):**

**\*DATE OF BIRTH: \*FIRST LANGUAGE:**

please use this format dd/mm/yyyy

**WHAT IS YOUR ETHNIC GROUP?**

**CHOOSE ONE OPTION THAT BEST DESCRIBES YOUR ETHNIC GROUP OR BACKGROUND:**

|  |  |
| --- | --- |
| **WHITE** | **PLEASE TICK √** |
| 1. **ENGLISH / WELSH / SCOTTISH / NORTHERN IRISH / BRITISH**
 |  |
| 1. **IRISH**
 |  |
| 1. **GYPSY OR IRISH TRAVELLER**
 |  |
| 1. **ANY OTHER WHITE BACKGROUND (*please describe*)**
 |  |
|  |  |
| **MIXED / MULTIPLE ETHNIC GROUPS** |
| 1. **WHITE AND BLACK CARIBBEAN**
 |  |
| 1. **WHITE AND BLACK AFRICAN**
 |  |
| 1. **WHITE AND ASIAN**
 |  |
| 1. **ANY OTHER MIXED / MULTIPLE ETHNIC BACK GROUND (*please describe*)**
 |  |
|  |  |
| **ASIAN / ASIAN BRITISH**  |
| 1. **INDIAN**
 |  |
| 1. **PAKISTANI**
 |  |
| 1. **BANGLADESHI**
 |  |
| 1. **CHINESE**
 |  |
| 1. **ANY OTHER ASIAN BACKGROUND (*please describe*)**
 |  |
|  |  |
| **BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH**  |
| 1. **AFRICAN**
 |  |
| 1. **CARIBBEAN**
 |  |
| 1. **ANY OTHER BLACK / AFRICAN / CARIBBEAN BACKGROUND (*please describe*)**
 |  |
|  |  |
| **OTHER ETHNIC GROUP**  |
| 1. **ARAB**
 |  |
| 1. **ANY OTHER ETHNIC GROUP (*please describe*)**
 |  |

|  |  |  |
| --- | --- | --- |
| **\*are you new to the uk****\*date you arrived in uk** | * **yes**

 please use this format dd/mm/yyyy | * **no**
 |
| **\*DO YOU SPEAK ENGLISH** | * **yes**
 | * **no**
 |
| **\*CAN YOU READ ENGLISH** | * **YES**
 | * **NO**
 |
| **\*DO YOU REQUIRE AN INTERPRETER** | * **YES**
 | * **NO**
 |
|  |  |  |
| **please tell us which language you use** |  |  |

|  |  |  |
| --- | --- | --- |
| **HAVE YOU EVER SERVED IN THE BRITISH ARMED FORCES?** | * **YES**
 | * **NO**
 |

**\*HOME ADDRESS:**

**\*POSTCODE:**

**HOME PHONE NUMBER: MOBILE PHONE NUMBER: WORK PHONE NUMBER:**

**EMAIL ADDRESS: (PLEASE WRITE CLEARLY)**

**Your next kin is your closest blood relative; i.e. mother, father, husband, wife, brother, sister, child.**

**NEXT OF KIN NAME:**

TITLE FIRST NAME SURNAME/FAMILY NAME

**RELATIONSHIP:**

**PHONE NUMBER:**

|  |  |  |
| --- | --- | --- |
| **NEXT OF KIN DATE OF BIRTH:** **NEXT OF KIN HOME ADDRESS:**  |   please use this format dd/mm/yyyy |  |

**IF YOU DO NOT HAVE A NEXT OF KIN PLEASE PROVIDE EMERGENCY CONTACT DETAILS:**

**EMERGENCY CONTACT NAME:**

TITLE FIRST NAME SURNAME/FAMILY NAME

**RELATIONSHIP:**

**PHONE NUMBER:**

|  |  |  |
| --- | --- | --- |
| **EMERGENCY CONTACT ADDRESS:** |  |  |

**WHAT IS YOUR CURRENT**

**RELIGION, IF ANY:**

|  |  |  |
| --- | --- | --- |
| **CAN WE CONTACT YOU BY TEXT** | * **YES**
 | * **NO**
 |
| **CAN WE CONTACT YOU BY EMAIL** | * **YES**
 | * **NO**
 |
| PLEASE NOTE THAT WE MAY SEND YOU INFORMATION OF A CONFIDENTIAL NATURE USING A SECURE NETWORK. IT IS THE PATIENT’S RESPONSIBILITY TO ENSURE THEIR EMAIL IS PROTECTED FROM MALWARE**THERE MAY BE OCCASIONS WHEN WE CORRESPOND WITH YOU BY LETTER.** **WHAT IS YOUR PREFERRED** **METHOD OF COMMUNICATION?****PLEASE INFORM US IF YOU HAVE** **ANY ADDITIONAL INFORMATION** **OR COMMUNICATION NEEDS.** |
|  |  |  |
|  |
| **Please let us know if you care for somebody, we may be able to help you.****You are a young carer if you are aged 18 years and younger and look after someone in your family who has a disability, long term illness, or is affected by mental ill health or substance abuse.** **Please can all carer's, including young carer’s, complete the attached ‘Carer’s Identification Form’ at the end of this questionnaire.** |
| **ARE YOU A CARER** | * **YES**
 | * **NO**
 |
| **ARE YOU A YOUNG CARER?** | * **YES**
 | * **NO**
 |

**IF YES PLEASE GIVE DETAILS OF WHO YOU CARE FOR:**

**FULL NAME: RELATIONSHIP:**

|  |  |  |
| --- | --- | --- |
| **DOES SOMEONE CARE FOR YOU?** | * **YES**
 | * **NO**
 |

**IF YES PLEASE GIVE YOUR CARER’S DETAILS:**

**NAME: RELATIONSHIP:**

**TELEPHONE NUMBER:**

**DO YOU HAVE ANY KNOWN ALLERGIES:**

**DO YOU HAVE ANY KNOWN LONG TERM HEALTH CONDITIONS (CURRENT & PAST):**

(I.E CANCER, DIABETES, HEART DISEASE, ASTHMA, COPD)

**DOES YOUR FAMILY HAVE A HISTORY OF LONG TERM HEALTH CONDITIONS:**

**FAMILY MEMBER: HEALTH CONDITION:**

PLEASE USE THE BACK OF THIS FORM IF YOU NEED TO LIST ADDITIONAL INFORMATION.

**PLEASE USE THE EQUIPMENT IN THE WAITING ROOM TO PROVIDE THE FOLLOWING INFORMATION:**

|  |  |
| --- | --- |
| **HEIGHT (cm):** |  **WEIGHT (kg):**  |
|    |   |

**BLOOD PRESSURE:**

|  |  |  |  |
| --- | --- | --- | --- |
|  **SYS** **SMOKING STATUS:** |  **DIA** * **NEVER SMOKED**
 |  **PUL*** **EX SMOKER**
 | * **CURRENT SMOKER**
 |

**IF YOU SMOKE PLEASE TELL US HOW MANY CIGARETTES YOU SMOKE EACH DAY:**

**NUMBER OF UNITS OF ALCOHOL PER WEEK:**

PLEASE USE THE CHART BELOW AS A GUIDE:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **UNITS** | **2** | **2.5** | **2** | **1** | **9** |
|  |  |  |  |  |  |
|  | Pint of Regular Beer/Lager/Cider | Alcopop or can of Lager | Glass of Wine (175ml) | Single Measure of Spirits | Bottle of Wine |

**NUMBER OF HOURS OF EXERCISE PER WEEK:**

PLEASE TICK THE BOX THAT APPLIES

|  |  |
| --- | --- |
| **I DO NO PHYSICAL EXERCISE**  |  |
| **I EXERCISE LESS THAN ONE HOUR PER WEEK** |  |
| **I EXERCISE BETWEEN 1-3 HOURS PER WEEK** |  |
| **I EXERCISE OVER 3 HOURS PER WEEK** |  |

**\*IT IS THE PRACTICE POLICY TO SEND PRESCRIPTIONS ELECTRONICALLY TO THE PHARMACY OF YOUR CHOICE. PLEASE PROVIDE YOUR CHOSEN PHARMACY NAME AND LOCATION:**

WE REQUIRE ALL ADULTS NEW TO THE UNITED KINGDOM TO **COMPLETE THE ATTACHED ADULT IMMUNISATION FORM.** THIS IS SO WE CAN ENSURE YOUR MEDICAL RECORD IS UP TO DATE.

We recommend that patients sign up to the **NHS App**. If you do not have the technology to use the app, we also recommend patient online access. Both options provide you with the facility of making/cancelling appointments, ordering medication and viewing your medical information. If you wish to opt for patient access, please complete the attached request form. You will receive an email or letter with access details once your account has been authorised.

Parents registering a child aged 11 to 16 years: please be aware that you will need to apply for proxy access should you wish to control access to your child’s record and online services. Please ask a member of our reception team for a proxy access request form if you require this service.

Patients with a sensory impairment or learning disability will have their records coded so that we may better communicate with you. Please be aware that this information is shared with other care providers.

Patients that wish to withdraw their consent to their chosen form of communication, will need to inform the practice in writing.

Patients that wish to share their medical information with a carer/relative/friend/guardian will need to inform the practice of this instruction in writing.

**\*SIGNATURE: \*DATE:**

PARENT/CARER/GUARDIAN PLEASE USE THIS FORMAT dd/mm/yy

Christchurch Surgery Willow Surgery

 North Street Hill House Road

 Downend Downend

 Bristol Bristol

 BS16 5SG BS16 5FJ

 0117 9709 500 0117 9709 500

**PATIENT ONLINE ACCESS REQUEST**

|  |  |
| --- | --- |
| PATIENT NAME |   |
| DATE OF BIRTH |  |

I request online access to (please tick where applicable):-

|  |  |
| --- | --- |
| APPOINTMENT BOOKING |  |
| PRESCRIPTION ORDERING |  |
| ACCESS TO DETAILED CARE RECORDS  | *For access to your Detailed Care Records please ask a member of our Patient Assistant Team for the relevant Form* |

**Notice to the Patient:**

Some of the information in your medical record written by our GP’s and clinical staff may be highly technical and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

It is your choice whether you wish to share your information with others however it is important to understand that it is your responsibility to keep the information safe and secure. Should you wish to provide others with access to your online facilities, you will need to complete a Proxy Access Form, a member of our Patient Assistant Team can provide you with this.

If you think you may be pressured into revealing details from your patient record to someone else against your will then it is best you do not register for access at this time. Please contact the surgery for an appointment with a GP if you feel you are being coerced into sharing your personal information.

For further information on how best to use our online facilities please use the following link: [https://www.england.nhs.uk/wp-content/uploads/2016/11/pat-guid-getting-started-gp-online.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/11/pat-guid-getting-started-gp-online.pdf%20)

I confirm that I have read the above statement and would like Downend Health Group to set up online patient access on my behalf.

Patient Signature ……………………………………………………………………..

Date ……………………………………………………………………..

**INTERNAL USE**

|  |  |
| --- | --- |
| PHOTOGRAPHIC ID PROVIDED? |  |
| PROOF OF ADDRESS PROVIDED? |  |
| ONLINE ACCESS AUTHORISED? |  |
| LOG IN & PASSWORD DETAILS EMAILED? |  |
| Authorisation Date:Staff Name:Position: |  |

***The following is an external document. Completed forms will be sent to the Carer’s Centre who may be able to offer Carer’s help and advice.***

**Carer Registration and Consent Form.**

Do you look after someone – a relative, friend or neighbour who is ill, frail or disabled and is unable to or has difficulty looking after themselves? Do you give support to someone who has mental health needs or misuses alcohol or drugs?

If you are, that means you are a carer and by registering that you are a carer with the Practice it could mean that we are able to offer you more support.

Please complete this form and hand it to reception or post it to us.

**Name of GP Surgery**………………………………………………………………

**YOUR DETAILS:**

Surname:……………………….. Forename:………………………. Mr/Ms/Miss/Other

Address:……………………………………………………………………………

………………………………………………………………………………………

………………………………………………………………………………………

Home No:……………………………….. Mobile No:………………………….

Email:…………………………………… DOB…………………………..

Relationship to person cared for:……………………………

Please give brief summary of health problems of the person you care for:

I live with the person I care for**: Yes** **[ ]  No** **[ ]**

I am their next of kin: **Yes [ ]  No [ ]**

I am their emergency contact: **Yes [ ]  No [ ]**

I am the main carer: **Yes [ ]  No [ ]**

Is the person you care for over or under 18? Over 18 / Under 18

I give consent to being registered as a carer with this practice**:**

Signed:…………………………………. Date:………………………..

I give permission for my details to be passed to the local Carers support centre for advice and support.  **Yes** **[ ]  No** **[ ]**

**Protected Characteristics –** these are not mandatory to answer, however they will help us to improve our service.

Ethnic Origin…………………………………. Religion …………………………….. Sexual Orientation………………………….. Do you have a disability? Yes / No

Do you identify as transgender? Yes / No

**Practice Administrative staff only:**

If the carer has agreed for the information to be sent to Bristol and South Gloucestershire Carers Centre then please use the Carers Support Centre on line referral which can be found at:

www.carerssupportcentre.org.uk/professionals/

**Patient Medical Consent Form.**

This section should be completed by the person you care for. This is to make sure that they give their consent to register you as their carer.

**DETAILS OF PERSON CARED FOR:**

Surname:……………………..…..………. Forename:……………………….

Address:……………………………………………………………………………

………………………………………………………………………………………

………………………………………………………………………………………

Home No:……………………………….. Mobile No:…………………………..

Email:……………………………………….….… DOB………………………

I give consent for the above information about me to be recorded on the clinical record of the person who cares for me. **Yes [ ]  No [ ]**

I give consent for the details of my carer to be held on my medical records. **Yes [ ] No [ ]**

I give consent for relevant medical information to be shared with my carer. **Yes [ ]  No [ ]**

Signed:…………………………………….….. Date:…………………….

**THE DOWNEND HEALTH GROUP PATIENT PARTICIPATION GROUP**

**APPLICATION FORM**

The practice runs a Patient Participation Group (PPG); this is a group of people who are patients at the surgery who help to make the practice work for everyone. The group meet quarterly to discuss the services on offer and how improvements can be made. A background in healthcare is not essential and the ideas and experiences of ALL members are very important to us. We welcome new members from any community, group, gender, age, and ethnicity Meetings are held quarterly and are face to face at the practice. If you are interested in getting involved, please complete this form and return to reception. Candidates are selected to ensure a fair representation of our practice population.

|  |  |
| --- | --- |
| **NAME:** |  |
| **GENDER:** |  |
| **DATE OF BIRTH:** |  |
| **ADDRESS:** |  |
|  |  |
|  |  |
| **POSTCODE:** |  |
| **HOME TELEPHONE NUMBER:** |  |
| **MOBILE NUMBER:** |  |
| **EMAIL ADDRESS:** |  |
| **ETHNIC ORIGIN:** |  |
| **HOW OFTEN DO YOU COME TO THE PRACTICE:*****Please tick relevant box*** | **Regularly** |  |
| **Occasionally** |  |
| **Very Rarely** |  |
| **WHAT CAN YOU BRING TO THE PATIENT GROUP:*****Ideas, suggestions, comments*** |  |

**CONFIDENTIALITY/PRIVACY STATEMENT FOR PATIENT PARTICIPATION GROUP MEMBERS**

I understand that whilst attending meetings within the Practice, I may hear or see information about staff, patients, or other matters, and that the disclosure of this information to anyone is considered to be serious misconduct and could contravene The Data Protection Act. I also understand that unauthorised disclosure of confidential information is a serious matter for myself, the patient and the Practice and could lead to legal action to all parties involved.

I understand that the practice will collect and store my personal information provided in this form. I am aware that the practice Privacy Policy provides further information on how the practice manages personal data and this can be found on the DHG website or at each reception.

To ensure the smooth running of the PPG, I am aware that the practice will use my personal information to contact me by either text, email or phone.

I agree to the practice displaying my name, as a PPG member in both internal and external promotional material and on the practice website.

|  |  |
| --- | --- |
| **PRINT NAME:** |  |
| **SIGNATURE:** |  |
| **DATE:** |  |

**ADULT IMMUNISATION FORM - ADULTS NEW TO THE UNITED KINGDOM PLEASE COMPLETE**

*PLEASE REFER TO THE ATTACHED TRANSLATION GUIDE*

|  |  |
| --- | --- |
| **FIRST NAME:** |  |
| **LAST NAME:** |  |
| **DATE OF BIRTH:** |  |
| **ADDRESS:** |  |

|  |  |  |
| --- | --- | --- |
| **AGE** | **VACCINE** | **DATE ADMINISTERED** |
| **65 Years** | Pneumococcal (PPV) Vaccine  |  |
| **65 Years +** | Annual Influenza (Flu) Vaccine | This year’s date only |
| **70 years** | Shingles (Herpes Zoster) VaccineSingle dose |  |
| Shingles (Herpes Zoster) Vaccine(patients with weakened immune system)1st Dose |  |
| Shingles (Herpes Zoster) Vaccine(patients with weakened immune system)2nd Dose |  |

|  |
| --- |
| INTERNAL ONLY |
| Please return to the Administration Team. |

**Quick Chart of Vaccine-Preventable Disease Terms**

**Eastern European Languages**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **English** | **Bosnian**  | **Croatian** | **Polish** | **Romanian**  | **Russian** | **Serbian**  | **Slovak** | **Ukranian** |
|  |  |  |  |  |  |  |  |  |
| DTP | Detepe | Detepe |  | Di-Te-Per | АКДС | Detepe | DiTePe |  |
| Diptheria | Difterija | Difterije | przeciwko błonicy | Difteriei | дифтерия  | дифтерия  | záškrt | Дифтерії |
| *Haemophilus influenzae* type b | *Hemofilina influenca* tipa B | Haemophilus influenzae tipa b | Haemophilus influenzae typu b | Haemophilus influenzae tip b boala | гемофільной инфекции типа B |

|  |
| --- |
| Хаемопхилус инфлуензае тип Б болести  |
|  |

 |

|  |
| --- |
| Haemophilus influenzae typ b ochorenia  |
|  |

 |

|  |
| --- |
| гемофільної інфекції типу B захворювань  |
|  |

 |
| Hepatitis A | utica A, Hepatitis A | utica A, hepatitisa A | wirusowemu zapaleniu wątroby typu A | hepatita A | гепатит А | хепатитиса A | hepatitída A | гепатиту S |
| Hepatitis B | utica B, Hepatitis B | utica B, hepatitisa B | wirusowemu zapa-leniu wątroby typu B | hepatita B | гепатит B | хепатитиса Б | hepatitída B | гепатиту В |
| Human papillomavirus | Ljudski papiloma virus | papilomavirusi čovjeka | wirus brodawczaka ludzkiego | papilomavirus uman | вирус папилломы человека | људски папилома вирус | ľudský papillomavírus | вірус папіломи людини |
| Influenza | gripa | gripe | grypa | gripa | грипп | грип | chrípka | Грипу |
| MMR | MMR |  |  |  |  | MMR |  |  |
| Measles | rubeola | ospice | odra | pojarul | коpЬ | Μале бοгиње | morbilli, osýpky |  |
| Meningococcal conjugate |  | meningokoknog konjugirati | meningokokom sprzężenia | conjugate meningococice | менингококковая сопряженных | менингококне коњуговано | meningokokovej konjugovanou | менінгококова сполучених |
| Mumps  | zauške | zauŠnjaci | swinka | oreionul, oreion | свинка,ларотит | Эаушκе | parotitis | Кір |
|  |  |  |  |  |  |  |  |  |
| **English** | **Bosnian**  | **Croatian** | **Polish** | **Romanian**  | **Russian** | **Serbian**  | **Slovak** | **Ukranian** |
|  |  |  |  |  |  |  |  |  |
| Poliomyelitis  | djeja paraliza  | dječje paralize  | polio  | poliomielita  | пoлиомиелит  | дечје парализе  | detská obrna  | поліомієліту  |
| Pneumococcal conjugate  | upala plua  | pneumokoka konjugirano  | skoniugowanej szczepionki pneumokokowej  | pneumococic conjugat  | пневмококковоя конъюгированной  | Пнеумоцоццал коњунговане  | konjugovaná pneumokoková  | пневмококковой конъюгированной  |
| Rotavirus  | Rotavirus  | rotavirusa  | rotavirusy  | rotavirus  | ротавірусной  | рота-вируса  | Ροтавирус  | ротавірусної  |
|  |  |  |  |  |  |  |  |  |
| Rubella  | male boginje  | rubeola  | rozycka  | rubeola, rubeolei, pojar German  | краснуха  | Ρубеοла  | rubeola |  |
| Shingles (Herpes zoster) |  | šindra | półpasiec  | Herpes zoster (zona zoster) | опоясывающий лишай | херпес зостер (појасни херпес) | pásového oparu (pásový opar) | оперізуючий герпес (оперізуючий лишай) |
| Smallpox  | veliki boginje  | veliki boginje  | ospa  | variola, variolei  | оспа  | veliki boginje  | Kiahne |  |
| Tetanus  | tetanus  | tetanusa  | tężcowi  | tetanosului  | столбняк  | тетануса  | tetanus  | правця  |
| Tuberculosis  | tuberkuloza  | tuberkuloza  | gruzlica  | tuberculozei  | туберкулеѕ  | Tuberkuloza  | tuberkulóza  |  |
| Varicella (chickenpox)  | ospice  | varicella (vodene kozice)  | ospy wietrznej (ospa wietrzna)  | şi varicelă (varicelă)  | ветряная оспа (вітрянка)  | Варицелла (цхицкен богиње)  | ovčím kiahňam (ovčie kiahne)  | вітряної віспи (вітрянка)  |

**Quick Chart of Vaccine-Preventable Disease Terms**

**Western European Languages**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **English**  | **Dutch**  | **French**  | **German**  | **Italian**  | **Norwegian**  | **Portuguese**  | **Spanish**  | **Swedish**  |
|  |  |  |  |  |  |  |  |  |
| DTP  | DKTP  | DT Coq, DTC  |  |  |  | Tríplice |  | **trippel** |
| Diphtheria  | difterie  | diphtérie  | diphtherie  | difterite  | difteri  | difteria  | Difteria  | difteri  |
| *Haemophilus influenzae* type b  | Haemophilus influenzae b  | Haemophilus influenzae de type b  | Haemophilus influenzae type b  | Haemophilus influenzae b  | Haemophilus influenzae tipe b  | doenca Haemophilus influenzae tipo b  | Hemófilo tipo b, Haemophilus influenzae tipo b  | Haemophilus influenzae typ b  |
| Hepatitis A  | hepatitis A  | hepatite A  | hepatitis A  | epatite A  | hepatitt A  | hepatite A  | hepatitis A  | hepatit A  |
| Hepatitis B  | hepatitis B  | hepatite B  | hepatitis B  | epatite B  | hepatitt B  | hepatite B  | hepatitis B  | hepatit B  |
| Human papillomavirus  | humaan papillovirus  | papillovirus humaines  | humanen papillovirus  | il papillovirus umano  | humant papillomavirus  | virus do papiloma humano  | Virus del papiloma humano  | mänskliga papillovirus  |
| Influenza (“flu”)  | influenza (griep)  | grippe  | influenza (grippe)  | l’nfluenzae  | influensa  | influenza (gripe)  | influenza (gripe)  | influensa  |
| MMR  | BMR  | ROR  | MMR  | MPR  |  | SPR | SRP | MPR |
| Measles  | mazelen  | rougeole  | masern  | morbillo  | meslinger  | sarampo  | sarampión, sarampión comun  | mässling  |
| Meningococcal conjugate  | meningokokken conjugaat  | conjugué contre le méningocoque  | meningokokken konjugatimpfstoff  | coniugato men-ingococcico  | meningokokksyk-dom konjugert  | meningocóccica conjugada  | meningococo conjugada  | meningokockinfek-tion konjugatet  |
| Mumps  | bof  | oreillons  | ziegenpeter  | parotite  | kusma  | caçhumba  | paperas, parotiditis  | påssjuka  |
| Pertussis (Whooping cough)  | kinkhoest  | coqueluche  | keuchhusten  | pertosse (tosse asinina)  | kikhoste  | coqueluche  | coqueluche (tos ferina)  | kikhosta  |
| **English**  | **Dutch**  | **French**  | **German**  | **Italian**  | **Norwegian**  | **Portuguese**  | **Spanish**  | **Swedish**  |
|  |  |  |  |  |  |  |  |  |
| Rotavirus  | rotavirus  | rotavirus  | rotavirus  | rotavirus  | rotavirus  | rotavírus  | rotavirus  | rotavirus  |
| Rubella  | rode hond  | - rubéole - rubéola  | röteln  | rosolia  | røde hunder  | rubéola (sarampo alamão)  | rubéola, sarampión aleman  | röda hund  |
| Shingles (Herpes zoster)  | gordelroos (herpes zoster)  | zona (l’herpès zoster)  | gürtelrose (herpes zoster)  | fuoco di Sant’Antonion (l’herpes zoster)  | helvetesild (herpes zoster)  | zona (herpes zoster)  | zona de matojos (herpes)  | bältros (herpes zoste)  |
| Smallpox  | pokken  | variole  | pocken  | vaioloso  | kopper  | varíola  | viruela  | smittkopper  |
| Tetanus  | tetanus  | tétanos  | wundstarrkrampf  | tetano  | stivkrampe  | tétano, tetânica  | tétanos, tetánica, tétano  | stelkramp  |
| Tuberculosis  | tering  | tuberculose  | tuberkulose  | tubercolosi  | tuberkulose  | tuberculose  | tuberculínica  | tuberkulos  |
| Varicella (chickenpox)  | varicella (waterpokken)  | varicelle  | varizellen (windpocken)  | varicella  | vannkopper (vannkopper)  | varicella (catapora)  | varicela  | vattkopper  |

**SEX, GENDER & IDENTITY**

The practice follows the PCSE electronic registration process and their predetermined questions. This process limits the practice on the types of gender identity options we can offer. For the purpose of this registration, it is important that patients inform us of their birth gender so that we can arrange the smooth transfer of medical records from your previous practice.

Downend Health Group understands that there are occasions when a patient may wish to change their gender. The practice treats such changes with care, sensitivity and in the most appropriate way. Patients do not need to have undergone any form of medical re-assignment for this change to be officially recognised and a Gender Recognition Certificate (GRC) is no longer deemed necessary. Please let us know if you wish to change your name, title and/or gender markers on your healthcare records so that we can discuss the options with you.

The practice has appointed a designated Gender Identity Lead with the expectation of providing a high-quality service and to promote respect, dignity and equality for trans patients. The Lead participates in regular training programmes on gender dysphoria and promotes awareness amongst the DHG team.