

Patient Health Questionnaire for Under 16 years of Age



Stockwell Gate
 Mansfield
 NG18 5GG
 Tel: 01623 400100
 Fax: 01623 400101
 www.orchard-medical.co.uk

Patient Details

First Names:	Date of Birth:	
Surname:		
Home Address:	Home Tel:	First Language:
	Work Tel:	
Postcode:	Mobile:	
	Email:	
Name & Address of Previous GP:		
Name & Address of Current School:		

Ethnic Group

White	<input type="checkbox"/> British
	<input type="checkbox"/> Irish
	<input type="checkbox"/> Other (please specify)

Black	<input type="checkbox"/> Caribbean
	<input type="checkbox"/> African
	<input type="checkbox"/> Other (please specify)

Asian	<input type="checkbox"/> Indian
	<input type="checkbox"/> Pakistani
	<input type="checkbox"/> Chinese
	<input type="checkbox"/> Other (please specify)

Mixed	<input type="checkbox"/> White + Black
	<input type="checkbox"/> Pakistani
	<input type="checkbox"/> Chinese
	<input type="checkbox"/> Other (please specify)

Proof of Identity and Address Provider?

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Passport	<input type="checkbox"/> Hospital letter/GP Letter
<input type="checkbox"/> Child Tax Credit Letter	<input type="checkbox"/> Child's Red Book	<input type="checkbox"/> Other (please state) ie, medical card etc

Please provide 2 of the above for each child

Medical Information

Please list any serious illnesses/operations/accidents/disabilities/ allergies and the year they took place.

Relationship to Child

Parent/Parents (please state parent/parents full names: _____)

Guardian

Carer/Foster Parent, please provide proof of responsibility.

Other (please state)

Are there any residency orders in place for the child/children you are registering?

Yes/No

If yes please give details: _____

Immunisations

Are you child's vaccinations up to date?

Yes No

Please could you bring your **CHILDS RED HEALTH RECORD BOOK** at your earliest convenience.

I believe all the information in my new patient health questionnaire to be accurate and correct to the best of my knowledge (please sign and date below when you visit the practice)

Signature: _____ Date: _____

Information for New patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

- a) Express consent for medication, allergies, and adverse reactions only. You wish to share information about medication, allergies, and adverse reactions only.
- b) Express consent for medication, allergies, adverse reactions, and additional information. You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
- c) Express dissent for Summary Care Record (opt out). Select this option, if you DO NOT want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose one of the options below and return the completed form to your GP Practice:

Yes – I would like a Summary Care Record

Express consent for medication, allergies, and adverse reactions only.

or

Express consent for medication, allergies, adverse reactions, and additional information.

No – I would not like a Summary Care Record

Express dissent for Summary Care Record (opt out).

Name of Patient:

Address:

Postcode: Date of Birth:

NHS Number (if known):

Signature: Date:

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name:

Please circle one: Parent Legal Guardian Lasting power of attorney for health and welfare If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

Consent Form

I, _____ (**Forename Surname**), have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet Sharing your GP record

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors' surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out *Circle Your Choice

I would* / would-not* like the information recorded at **Orchard Medical Practice** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in *Circle Your Choice

I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **Sender organisation name**, where I have granted those care teams the right to add to my shared data.

*** Delete as appropriate**

I understand that I can change my decision at any time.

Signed

Patient

Date Today's date

OR

Patient representative

Relationship to patient