Dunster & Porlock Surgeries

NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE (CHILD)

(Revised OCTOBER 2022)

This information will remain strictly confidential. Please make sure you answer all questions and sign the form.

PATIENT DETAILS	**PLEASE COMPLETE IN BLOCK CAPITALS**
TITLE: MISS/MS/OTHER (please state)	SURNAME:
FORENAMES:	DATE OF BIRTH:

Home Telephone:

A landline must be provided if possible.

Patients aged between 11-15 will not be given access to on-line appointments and mobile phone numbers for their parents will not be recorded or used as text reminders

Mobile Telephone: E-mail:

If you are registering a child under 18, please state:

Mother's Name: Father's Name:

Mother's Address: Father's Address:

Contact Number: Contact Number:

Please state who has Parental Responsibility

Joint/Mother/Father/Other (delete as appropriate)

CHOICES ABOUT SHARING YOUR INFORMATION

Summary Care Record (SCR):

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 by ticking the appropriate box:

☐ **Express consent for medication, allergies and adverse reactions only.**
You wish to share information about medication, allergies for adverse reactions only.

☐ **Express consent for medication, allergies, adverse reactions and additional information.**
You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.

☐ **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Ethnicity

☐ White British ☐ White Irish ☐ White Other ☐ Black African

☐ Black Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi

☐ Chinese ☐ Other (please state) _____

What is your first language?

☐ English

☐ Other (please state) _____

WILL YOU NEED AN INTERPRETER YES/NO

Is the child registering a young carer and if so, who do they care for?

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNISATION HISTORY

Consent for children under 16 (Gillick Competence)

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well. If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

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

SIGNATURE ……DATE ……..

☐ Signed by Patient ☐ Signed on behalf of Patient

FOR PRACTICE USE ONLY

English not first language Likely to need interpreter	**Yes/No**
Registration received by Patient Adviser	
Completed and signed GMS1 (purple form)	
Completed and signed supplementary questionnaire	
Copy of immunisation history attached to form	
Registration entered on to EMIS	

NB: If patient has been registered at practice before check reason for returning has been supplied.