**Dear Patient,**

This set of questions has been designed to help us to get to know your child and any concerns or medical problems. **Please fill in the entire form or there could be delays in your registration.** All the information gathered from these questions will be handled confidentially. Your named accountable GP will be **Dr Nandanavanam**.

**Surname**: ……………………………………….……… **Forenames**: ………………………………..……………………………….

**Gender at birth: M / F Current Gender Identity:** ……………………………. **Preferred Pronouns:** ……………………………..

**Address**: …………………………………………………………………………..…………………………………………………………..……………

**Post Code**: …………………………… **Tel No**: ……………………………………… **Mobile No:** …………………………………………………..

**Email address:** …………..……………………………………………………………………………

**DOB**: .…../………/……. **Country of Birth**: ……………………………………………….………

Your Preferred Method of Contact (please circle): SMS / Telephone / Letter / Email

*This is how the surgery will contact you unless in an emergency*

**ETHNICITY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| White British | | Indian | Black Caribbean | Any Mixed Background | |
| Other White British | | Pakistani | Black African | Other Ethnic Group | |
| White Irish | | Chinese | Black British | Other | |
| White European | | Other Asian | Other Black | Patient Declined | |
| **Main Spoken Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Interpreter Needed: YES 🞏 NO 🞏** | | | |

**PRESENT ILLNESSES/TREATMENTS**

Please list all illnesses child is receiving treatment for:



**PRESENT MEDICINES (Prescribed)**

Please provide a printed list from your previous practice of any medicines or tablets you are taking at present and the illness for which you are taking them. If you require repeat medication, please provide us with either the last computer tear-off slip, showing the medication prescribed or the original containers showing the relevant information.

**If you do not have a printed list, please give details of any medication you take (prescribed or otherwise) on the next page:**

**MEDICATIONs**

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

Name of drug: …………………………………………………………………………………………………………….

Dosage: ……………………………………………………………………………………………………………………..

**ALLERGIES & DISABILITIES:**

Does your child have an allergy or sensitivity to any medicines, food, animals, etc.?  Yes  No

If yes please state :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a disability?  Yes  No If yes please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you class the disability as  **Slight**  **Moderate**  **Severe**

**(*Please note the answer to the above may have an impact on any future life insurance policy or private health insurance premiums*)**

Due to this disability does your child have a carer who looks after their daily needs? **Yes / No**

If “Yes”, please provide details of carer / care agency involved: …………………………….…………………………………………………..

Does your child have any communication difficulties that may require any additional assistance? (for example: sensory loss, language barrier etc.) **Yes / No**

**If yes, please write difficulty here or provide Autism / Learning Disability Passport for us to copy:**

**IDENTIFYING YOUNG CARERS:**

Does your child care for you anyone else in the home or elsewhere?

This can include helping with mobility, medications management, reminding you to do things etc. **Yes / No**

**If “Yes”, please state how they help:** ……………………………………………………………………………………………………………………….

**Please ask the receptionist about Young Carers support referral**

**CONTACT DETAILS:**

Please provide details below of adult with parental responsibility for the child. The Children Act 1989 sets out who has parental responsibility for a child. Mothers automatically have parental responsibility for their children a father usually has parental responsibility if he is:

● married to the child’s mother

● listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in)

● has a court order confirming parental responsibility.

With this in mind, please provide details of first and second points of contact for the child you’re filling this questionnaire for. **If there is a Court Order in place please provide a copy of this.**

**First Person:**

First Name: ­­­­­­­­­­­­­­­………………………………………………………………. Surname: ……………………………………………………………….

Please select relationship to Child by circling below applicable terms:

**Parent / Legal Guardian / Foster Carer / Care Agency / Lasting Power of Attorney / Legal Representative**

**Second Person (if applicable):**

First Name: ­­­­­­­­­­­­­­­………………………………………………………………. Surname: ……………………………………………………………….

Please select relationship to Child by circling below applicable terms:

**Parent / Legal Guardian / Foster Carer / Care Agency / Lasting Power of Attorney / Legal Representative**

At this Practice we understand that life circumstance can change and that you may not always be able to bring your child to Surgery yourself. In such circumstances you can nominate other people or agencies below who have your permission to bring the child to appointments and consent for treatment such as medications and immunisations.

You do not have to nominate someone at this time and can leave this section blank if you wish.

***Please be aware that should this change at any time you will need to inform the Surgery as soon as possible so we can update patient’s records to reflect this.***

First Name: ­­­­­­­­­­­­­­­………………………………………………………………. Surname: ……………………………………………………………….

Please indicate relationship to Child ie Grandparent, Family friend etc: ………………………………………………………….

First Name: ­­­­­­­­­­­­­­­………………………………………………………………. Surname: ……………………………………………………………….

Please indicate relationship to Child ie Grandparent, Family friend etc: ………………………………………………………….

**BACKGROUND:**

In order to facilitate some types of referrals we require extra information about children’s social background, please fill in the below details to ensure that should they be needed in future, we have this information to hand.

**School / Nursery Name**: ……………………………………………………………………………………….. **Postcode:** ……………………………..

**Health Visitor Name** (if applicable): ………………………………………………………………

Contact Number (if known): ………………………………………………………………………………………..

**Social Worker / Link Worker Name:** ………………………………………………………………………………………..

Contact number (if known): ………………………………………………………………………………………..

Email address (if known):………………………………………………………………………………………..

**Is Child on a current Child Protection Plan? Yes / No**

**Have they ever been on a Child Protection Plan? Yes / No**

**Is Child on a current Child in Need Plan? Yes / No**

**Have they ever been on a Child in Need Plan? Yes / No**

**Are there any other Agencies involved in Child’s care? For example, New Cross Hospital, Gem Centre, etc**

**Yes / No**

**If yes, please provide details:** …………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………………

**Patient Data Consent Form**

Please read the following carefully as it will give you information about how we protect, use and share, your electronic and paper-based health record.

1. **How we protect your child’s information within the Legislative Framework**

The purpose for which we hold and process both personal and medical data is to assist the Practice in the provision and administration of patient care. As guardian of this information, we endeavour to follow a code of conduct which encompasses ‘The Access to Medical Records Act 1990’, ‘The Freedom of Information Act 2000’, ‘The Data Protection Act 1998’, ‘The Common Law Duty of Confidentiality’ and adhere to the NHS Code of Practice when sharing information between health professionals in support of patient care. We will **not** share or disclose your child’s information with other 3rd parties (outside of the said purpose), unless we have your signed consent to do so.

We ask that you consent to the information that is recorded about your child, being made available to other NHS care services that care for you now, and in the future for e.g. Secondary Care Services, District Nursing Services, Community Services etc.

**Please tick box to note consent:**

1. **Summary Care Record – emergency care summary**

The NHS introduced the Summary Care Record, to ensure that those caring for your child in an emergency situation have enough information to treat them safely. The Summary Record contains information about any medicines they are taking, allergies and any bad reactions to medicines that they have had.

**Please tick box to note consent**

Further information can be accessed from the follow links:

[www.nhs**carerecords**.nhs.uk](http://www.nhscarerecords.nhs.uk)

[www.legislation.gov.uk](http://www.legislation.gov.uk)

**Please let us know if you do not want a Summary Care Record or to share your child’s information with other NHS Services and we will provide you with an opt-out form.**

1. **Messages to patient’s via Text (SMS) and Email**

The practice offers SMS Text messaging service to your mobile phone. We use this service in several ways:

* To remind patients about their appointments
* To ask them to contact the practice
* To inform them on current health screening opportunities and in some cases about test results etc

(None of these messages will contain your name)

**Due to the personal content of these messages, it is very important that you keep the Practice informed of any changes to your mobile phone number or email address.**

(Please note that the NHS mail messaging service utilises the public telephone network and as such full security is not guaranteed) **Please tick box to note consent**

1. **Medical Photography Consent**

To help practice staff, there may be occasions when a clinician requires a medical image to review and compare particular skin lesions. We therefore ask that you give consent for medical imaging for medical purposes only.

**Please tick box to note consent**

**Parent or Guardian’s Signature**

I …………………………………………………………………………………… (Your Name) Can confirm I hold parental or court ordered responsibility for this child and I give my consent for Ashfield Road Surgery & Pendeford Health Centre to hold and process their personal data as noted above in the Patient Data Consent Form

**Signature**………………………………………………………………………. **Date**……………………………………….

**Relationship to Patient:** ……………………………………………………………………….

**Consent to proxy access to GP online services**

**Note**: **If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the Practice to be in the patient’s best interest section 1 of this form may be omitted.**

**Section 1 - To be completed by children over 12 (if under 12 then skip to section 2)**

I **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** . (Name of Patient), give permission to my GP practice to give the following people ….………………………………………………………………..…………….. proxy access to the online services as indicated below in section 2.

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand the risks of allowing someone else to have access to my health records.

I have read and understand the information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Accessing the medical record for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name of patient) | 🞏 |

**Section 3**

I/we…………………………………………………………………………….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……… (name of patient).

I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement | 🞏 |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | 🞏 |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date/s |

**The patient -** This is the person whose records are being accessed

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address | |
| Email address | |
| Telephone number | Mobile number |

**The representatives -** These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription.

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| Address (tick if both same address 🞏)  Postcode | Address (tick if both same address 🞏)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| The patient’s NHS number | | The patient’s practice computer ID number | |
| Identity verified by  (initials) | Date | Method of verification  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| Proxy access authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled    Prospective 🞏  Retrospective 🞏  All 🞏  Limited parts 🞏  Contractual minimum 🞏 | | Notes / comments on proxy access | |