

# HOLMHURST MEDICAL CENTRE

## New Patient Questionnaire –Under 16s

Please complete as many questions as you can about your child. The information will help the practice to provide better care for your family whilst your notes are in transit from your previous GP.

### **Childs Information:**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
\_\_\_\_\_ Postcode: \_\_\_\_\_  
Main Spoken Language: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
School Name/ Brief Address (if applicable): \_\_\_\_\_  
Name and Address of Previous GP (if applicable): \_\_\_\_\_  
\_\_\_\_\_

### **Parents or Guardians Information:**

Name: \_\_\_\_\_ Number: \_\_\_\_\_  
Relationship to this child: \_\_\_\_\_

### **PLEASE COMPLETE/DELETE AS APPROPRIATE:**

#### **Child's Medical History**

Has your child ever had any of the following:

Measles	Yes/No	Mumps	Yes/No
German Measles	Yes/No	Asthma	Yes/No
Whooping Cough	Yes/No	Fits	Yes/No
Chicken Pox	Yes/No		

Has your child had any **operations, hospital admittances, other serious illnesses or know allergies in the past?** (Please list with dates where possible)

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**Family History:**

Have the parents, brothers or sisters suffered with any of the following:

Asthma	Yes/No	Diabetes	Yes/No
High Blood Pressure	Yes/No	Heart Problems	Yes/No
Glaucoma	Yes/No	Cancer	Yes/No
TB	Yes/No	Epilepsy	Yes/No

Other major illnesses **(please list)**

VACCINATIONS – **IT IS MOST IMPORTANT THAT WE KNOW WHAT VACCINATIONS YOUR CHILD HAS HAD AND WHEN EACH OF THESE WAS GIVEN – IF UNSURE OF PRECISE DATE PLEASE GIVE APPROXIMATE DATE.**

Vaccination	2 mths Date given	3 mths Date given	4 mths Date given	12 mths Date given	13 mths Date given	40 mths Date given
Diphtheria	1)	2)	3)			B)
Tetanus	1)	2)	3)			B)
Pertussis	1)	2)	3)			
Polio	1)	2)	3)			B)
HIB	1)	2)	3)	B)		
Men. C		1)	2)	B)		B)
Pneumococcal	1)		2)		3)	
Rotavirus						
Men. B	1)		2)	B)		
Measles					1)	B)
Mumps					1)	B)
Rubella					1)	B)

SMOKING STATUS – (If you are 15 and over)

Have you ever smoked? Yes/No

Are you currently a smoker? Yes/No If yes, how many a day?

**If you are, we STRONGLY advise you to consider stopping. We may be able to help you stop, through our nurse-run smoking cessation clinic**

Any other information that you want to tell us about:

.....  
.....

**Childs main spoken language is.....**

**What is their ethnic group?**

Please indicate your ethnic group below by choosing ONE section from A to E, (or F if you do not wish to give this information) then tick the appropriate box to indicate your cultural background. **(It is important for us to have this information to enable us to give a better level of care)**

**A. WHITE**

- British
- Irish
- Any other White background, please state here.....

**B. MIXED**

- White & Black Caribbean
- White & Black African
- White & Asian
- Any other Mixed background, please state here.....

**C. ASIAN OR ASIAN BRITISH**

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background, please state here.....

**D. BLACK OR BLACK BRITISH**

- Caribbean
- African
- Any other Black background, please state here.....

**E. CHINESE OR OTHER ETHNIC GROUP**

- Chinese
- Any other background, please state here.....

**F. DECLINED OR REFUSED**

- Declined/Refused to reveal ethnic group

Parents/guardians signature ..... Date .....

**THANK YOU FOR COMPLETING THIS FORM**

**Consent from Patient for Alternative Methods of Contact**

In accordance with the Data Protection Act, the Practice requires written consent from any patient who is happy for us to share clinical information with a named third party, leave messages on an answerphone or contact you by email.

Please could you complete the following as appropriate:

***I give consent for the Practice to leave messages on my answerphone & to send text messages to my mobile phone regarding this child:-***

Home: ..... Mobile: .....

***I give consent for the Practice to contact me using my email address regarding this child:-***

My email address is .....

I understand that an email may contain confidential information about this child and that the security of emails cannot be guaranteed on the Internet.

***Please remember to advise the Practice of any changes to your email address.***

***I would like to be given access to SystmOnline for this child (online request service for repeat prescription requests and online booking of GP appointments):***

Yes/No (please indicate)

***NB: Please note that photo ID and proof of address must be provided for access to online services***

**This consent form will remain in force from the date written below until this child turns 16 years of age:**

**Signed** .....

**Print Name** ..... **Date:** .....

For the attention of Holmhurst Medical Centre

**OPT OUT FORM FOR THE CARE.DATA SCHEME**

This opt out form indicates my decisions about sharing my information, as described in the leaflet "Better Information means Better Care", and under the national scheme known as "care.data"

These decisions relate to the care.data scheme only.

Please ensure that my GP record is coded in accordance with my instructions below

(please tick the appropriate box/boxes):

Please prevent my Personal Confidential Data being sent from my GP practice (Holmhurst Medical Centre) to the Health and Social Care Information Centre

Please prevent my Personal Confidential Data gathered from **any** health and social care setting from leaving the Health and Social Care Information Centre

I am aware of the implications of this request and understand that it will not affect the care I receive, that I may change my mind at any time and that I will inform you if I subsequently decide to opt back into this system.

Name (Please use CAPITAL letters): \_\_\_\_\_

NHS Number (if known): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



## Your emergency care summary

Dear Patient

### Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.
- **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff.**

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) (01737 214842), GP practice staff, visit the website ([www.surreypct.nhs.uk](http://www.surreypct.nhs.uk)) or [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or requested from the dedicated **NHS Summary Care Record Information Line on 0300 123 3020.**

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Holmhurst Medical Centre



Your emergency care summary

CONFIDENTIAL

## OPT-OUT FORM

### Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

**A. Please complete in BLOCK CAPITALS**

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

**B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B**

Your name ..... Your signature.....

Relationship to patient..... Date .....

**What does it mean if I DO NOT have a Summary Care Record?**

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

**FOR NHS USE ONLY**

Actioned by practice: yes / no

Date.....

Ref: 4705