

NEW PATIENT QUESTIONNAIRE – (Under 16 year old)

To be completed by parent/guardian along with - Family doctor services registration form (GMS1)

Welcome to **The Lakes Medical Practice**. Please complete this form **AND** the family doctor services registration form (GMS1). You will also need to bring in the child's Birth or adoption certificate

Title: Ms, Mrs ,Mr Etc	
Surname/Family Name:	
First Name:	
Middle Name:	
Known as:	
Date of birth:	
NHS Number (if known)	
Gender:	
Ethnicity/Background:	
White	English/Welsh/Scottish/Northern Irish/British
	Irish
	Other, Please specify:
Mixed/Multiple ethnic groups	White and Black Caribbean
	White and Black African
	White and Asian
	Other, Please specify:
Asian/Asian British	Indian
	Pakistani
	Bangladeshi
	Chinese
	Other, Please specify
Black/ African/Caribbean/Black British	African
	Caribbean
	Other, Please specify:
Other ethnic group	Arab
	Other, Please specify:
Main Language:	
Interpreter Required:	Yes No

CURRENT Address Details:

House name or Flat number:		
Number & Street		
Town/City		
County:		Postcode:
Access Instructions such as keycode:		

PREVIOUS Address Details, (if recently relocated or moved in the last 5 years):

House name or Flat number:		
Number & Street		
Town/City		
County:		Postcode:

CONTACT DETAILS:

Home Tel Number:		
Mobile Number:		
Who do these contact details belong to and can they be used to give information about the patient (while under the age of 16)	Parent with parental responsibility	<input type="checkbox"/>
	Other relative or carer	<input type="checkbox"/>
	Can the contact details be used to give information Relating to the patient up until the age of, but not over 16	YES NO Please circle:

Who holds parental responsibility for the child (Under 16 Yrs old):

The practice will ask for proof of parental responsibility using a birth certificate.

Please Note: we cannot withhold information or refuse to speak to/deal with a person who holds parental responsibility and has proved as much, without a specific court order or there are proven and documented safeguarding concerns.

Name	
Contact details:	Telephone: Address:
Name	
Contact details:	Telephone: Address:

PREVIOUS GP details:

Previous GP Name:		
Surgery Name:		
Town/City		
County:		Postcode:

NAME(S) OF OTHER FAMILY MEMBERS AT THE SAME ADDRESS TO BE REGISTERED AT THIS PRACTICE:

NAME: DATE OF BIRTH

NAME DATE OF BIRTH.....

NAME:DATE OF BIRTH.....

You will need to complete a separate registration form for each family member. You will be added to our computerised system (EMIS) as connect by household

PERSONAL HISTORY

Has your child travelled outside of the UK in the last 2 Years, if so, where?	Yes (Please complete below)	No
Name of childs school or nursery or indicate if home schooled:		
Is your child a family member of a current or former member of the armed forces?	Yes (Please complete below)	No
Is your child housebound?	Yes (Please complete below)	No
Is your child registered as disabled?	Yes (Please complete below)	No
Does your child have a Carer?, If yes please give details	Yes (Please complete below)	No
Is your child a young carer?	Yes (Please complete below)	No
Do you have social worker? If Yes please provide name and contact details of social worker	Yes (Please complete below)	No
Has your child ever been subject to a child protection plan?	Yes (Please complete below)	No
Does your child have a hospital specialist or health visitor? If yes, please provide details?	Yes (Please complete below)	No

MEDICAL DETAILS – Does your child have any of the following, if yes please give details:

Known allergies:	
Chronic or serious illnesses, operations or disabilities:	
Please give details of any current medications or contraceptive pills you take	
Have you ever refused treatment/screening of any kind on behalf of your child, if so, please detail:	

It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS:	Date Given:
1 st Diphtheria, Tetanus, Whooping Cough, Polio, Hib , <i>rotavirus*</i> <i>age 2m</i>	
2 nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, <i>rotavirus*</i> <i>age 3m</i>	
3 rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib <i>age 4m</i>	
1 st Pneumococcal <i>age 2m</i>	
2 nd Pneumococcal <i>age 4m</i>	
1 st Meningitis C <i>age 3m</i>	
Hib/ Meningitis C	
1 st Measles, Mumps, Rubella (MMR) <i>age 12-13m</i>	
Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio <i>age 3y 4m</i>	
Booster Measles, Mumps, Rubella (MMR)	
Details of any other immunisations:	

ORGAN DONATION

From spring 2020, organ donation in England will move to an 'opt out' system. You may also hear it referred to as 'Max and Keira's Law'.

This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups.

You still have a choice if you want to be an organ donor or not when you die.

Please make sure you have recorded your consent or dissent on the GMS1 form.

If consent is given please sign the appropriate section, and please make sure that you make your loved ones aware of your choice.

Do you agree to our text messaging service?	Yes	<input type="checkbox"/>
This would be used for health related reasons such as results/appointments or to ask you to contact the practice.	No	<input type="checkbox"/>
Mobile number to be used.....,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

Summary care Record information and opt in/out:

The NHS Summary Care Record (SCR) is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record. It is used by authorised healthcare professionals, with the patient's consent, to support their care and treatment.

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

Summary Care Record Options:

YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had AND any other information that I have agreed with my GP Practice to have included in my Summary Care Records

NO, I wish to opt out and understand what this means

Please note: If you do not tick a preference, by signing this form, you will be consenting to a summary care record being created. If you wish to opt out please notify the practice and request an opt out form.

National Data Opt-Out Service information:

The national data opt-out, introduced on 25 May 2018, provides a secure and accessible way for patients to opt out of their confidential patient information being used for purposes other than their individual care and treatment except for certain exemptions

If you are happy about how your confidential patient information is used you do not have to do anything else.

If you do not want your confidential patient information to be used for planning and looking into new treatments you can:

View or change your national data opt-out choice at any time by using the online service at:

www.nhs.uk/your-nhs-data-matters or by calling 0300 3035678.

This is not something that can be changed or altered at the practice.

All the information given to the Practice as part of this form will be treated as Confidential. however to give your child the very best health care we work closely with the Health Visiting and School Nursing Service.

It is therefore our normal Practice to share the details of all children registering with the Practice with our NHS colleagues in Health Visiting and School Nursing.

If you would prefer that we DO NOT do this could you tick here

I have read and understood all of the information made available to me both via the practice website and leaflet, including information relating as to how my information will be used/stored. I request to register child named below as a patient at The lakes Medical Practice, Penrith.

Name of child.....

SIGNATURE of parent/guardian.....Date.....

OFFICE USE ONLY:

Date received:	ID checked by:	Input by:	Coding complete:	Scanned by: