New Patient Health Questionnaire (Under 16 Years)

Please note : if your child is aged 6 years and under, please send a copy of their vaccination record in order to complete registration

Date:

*Personal Details of Child (PLEASE USE CAPITALS)

First Name		**Surname/s**		
Date of Birth		**Sex**	Male	Female
Address				
City + Postcode				
Country of Birth		**First Language**		
Hospital Born (if in London				

Ethnic Origin *The classification is entirely voluntary but will help us to provide a better service. The level of care you will be offered at this practice will not be affected by decision to complete this.* Please tick most appropriate:

	British or Mixed British		White + Asian		Other Asian Background
	Irish		Other Mixed Background		Carribean
	Other White Background		Indian or British Indian		African
	White + Black Carribean		Pakistani or British Pakistant		Other Black Background
	White + Black African		Bangladeshi or British Bangladeshi		Chinese

Name of Previous GP/Surgery *(If applicable)*

Last previous address (*if applicable)*

Name of School (*if applicable*)

Does this child have any siblings registered at the surgery? *(If, yes, please provide their names and dates of birth)*

	Yes	**No**
Does this child have a 'Child Protection Plan?'		
Is this child a 'Looked after Child'? *(a child looked after by a local authority)*		
Does this child have a 'Child in Need' plan?		
Does this child have a social worker? *(If 'yes' please provide social workers details below)*		

Social Worker Details:

First Name		**Surname/s**	
Telephone			
Contact Address			

Medical History

Any medical or developmental problems?

Please list any other serious illnesses, operations or accidents that this child has had in the past
(Please give dates where possible)

Please list any medication that this child is currently taking:

Does this child have any allergies? Yes [ ] No [ ] *If Yes, Please list:*

Main Carer Information

First Name		Surname/s	
Date of Birth		**Relationship to Child**	
Your Telephone		**Your Mobile**	
Email		**First Language**	
Registered at this surgery?	Yes No		

Second Main Carer/ Family Member Information *(In case we are unable to contact Main Carer)*

First Name		Surname/s	
Date of Birth		**Relationship to Child**	
Your Telephone		**Your Mobile**	
Email		**First Language**	
Registered at this surgery?	Yes No		

Accommodation

Please tick which type of accommodation the child/family is currently living in:

Permanent
Temporary
Supported Housing
Other

All Patients

Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions, we share information from the patient records with the local Health Authority, Hospitals and other NHS/Partner organisations in the interests of patient care.

I agree, as the child's guardian, to their records being held under the above terms and I certify that the information I have provided is correct to the best of my knowledge.

Name:

Signature:

Date:

Nominated GP (To be filled in by Reception)
XacWQ - Patient allocated named accountable general practitioner
Xab9D -Informing patient of named accountable general practitioner

THE PEMBRIDGE VILLAS SURGERY

Sharing Your Medical Information

Your Choices

Health professionals are trained to keep your records secure and to manage them responsibly and in confidentc. There are several models for sharing data which have all been put into place nationally and locally in different years. Please see the Data Sharing Table which shows what information is shared and lins below for more information.

Summary Care Records: http://www.nhscarerecords.nhs.uk and http://systems.hscic.gov.uk
Care Data: http://www.nhs.uk/caredata
SystmOne Enhanced Sharing Data Model http://www.westlondonccg.nhs.uk/your-health/your-patient-record

Sharing your record benefits you because:

- You won't need to repeat your medical history
- You avoid unnecessary appointments and tests
- Your health professional has the right information at the right time

Patients have rights to dissent from sharing their data with other organisations.

Please tick your options **and sign** below to confirm:

Care Data:	**I do not consent** ☐	**I consent** ☐
SystmOne Enhanced Sharing Data Model:	**I do not consent** ☐	**I consent** ☐
Summary Care Record:	**I do not consent** ☐	**I consent** ☐
Summary Care Record Additional Info*:	**I do not consent** ☐	**I consent** ☐

***Summary Care Record Additional Information: If you wish to consent for additional information to be added to the SCR, coded items and the supporting free text will be added. This will include:**

- Significant Medical History (past and present)
- Reason for medication
- Anticipatory care information (such as information about the management of long term conditions)
- End of lie care information (from the SCCI1580 national dataset)
- Immunisations

The National Data Opt Out: For more information or to **"Opt Out"** please follow this link: **www.nhs.uk/your-nhs-data-matters/manage-your-choice/**

Full name: ……………………………………………………………………………….

Date of Birth: ……………………………………………………………………………….

Signature: ……………………………………………………………………………….

Date: ………………………….