Date Form Completed:	

Rothschild House Group
rothschildhousesurgery.co.uk

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UP TO 16Y)

TITLE:		**FIRST NAME:**	
SURNAME:	CURRENT SURNAME:		
	PREVIOUS SURNAMES:		
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS : **Postcode:**		**WHO ELSE LIVES IN THIS HOUSEHOLD?**(please tick all those that apply) Mum ☐ Dad ☐ Step parent ☐ Parent's partner ☐ Grandparents ☐ Brothers and sisters ☐ how many? ☐ Foster carer ☐ guardian ☐ Others- please state	
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad etc.)		**EMAIL:**	
		HOME:	
		MOBILE:	
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?		**MOBILE:**	**YES** ☐ **NO** ☐ (please tick)
		HOME:	**YES** ☐ **NO** ☐ (please tick)
Would you like to register with the Practice for SMS text message reminders?			**YES** ☐ **NO** ☐ (please tick)
WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) **and their relationship to the child**			
PREVIOUS ADDRESS:		**PREVIOUS GP's NAME & ADDRESS:**	

HEALTH HISTORY

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS?	YES ☐ NO ☐ (please tick)
If Yes, what was this and when? :	
DOES YOUR CHILD HAVE A DISABLITY OR CHRONIC CONDITION?	YES ☐ NO ☐ (please tick)

MEDICATION

IS YOUR CHILD ON ANY REGULAR MEDICATION?	YES ☐ NO ☐ (please tick)
If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy) (Please note you may be need to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	YES ☐ NO ☐ (please tick)
If Yes, please state type and name:	

Which school or nursery does your child attend?

Does your child have contact with any of the following? *(if so please can you tell us their names)*

A hospital specialist? **YES** ☐ **NO** ☐ (please tick)
A health visitor? **YES** ☐ **NO** ☐ (please tick)
A social worker? **YES** ☐ **NO** ☐ (please tick)
Any other health professionals? **YES** ☐ **NO** ☐ (please tick)

Has your child ever been under a Child Protection Plan?	YES ☐ NO ☐ (please tick)

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

* *rotavirus included since 2012*

IMPORTANT:

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 ☐

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the

NAME ______________________________ **DOB** ______________

What is your main language? [ ]

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
British	
Irish	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian British	
Pakistani, or Pakistani British	
Indian, Indian British	
Bangladeshi, Bangladeshi British	
Chinese, Chinese British	
Other Asian, please specify:	

D. African	
African, African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean British	
Black, Black British	
Other Caribbean or Black, please specify:	

Other, please specify:

If you would prefer not to provide this information, please tick here:	

FOR OFFCE USE:

Reg details to computer	
NHS no	
Scanned	
Sent to H/V S/N service	

NHS
Digital

Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.
Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice
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 on the form overleaf.

☐ **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.
Once you have completed the consent form, please return it to your GP practice.
You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of patient: ……………………………………………..........................

Date of birth: …………………………… Patient's postcode: …………………

Surgery name: …………………………… Surgery location (Town): ………..................

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

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

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: ………...

Please circle one

Parent	Legal Guardian	Lasting power of attorney for health and welfare

For GP practice use only

To update the patient's consent status, use the SCR consent preference dial

Summary Care Record consent preference	Read 2	CTV3
a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo.	XaXj6