SHAP MEDICAL PRACTICE

Shap Health Centre, Peggy Nut Croft, Shap, Penrith, CA10 3LW

New Patient Health Questionnaire – Child

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

Gender		**Date of birth**	
Forename(s)			
Surname		**Calling Name**	
Current address			
Home phone number			
School			
NHS number			
Previous address			
Previous GP			
Has your child been registered here previously? *If yes, please give dates.*			
Has your child moved to the UK from abroad? *If yes, give date of arrival in the UK.*			
Parent or guardian details:	Title: Surname: Forename: Relationship: Address: Telephone numbers:		
Consent: *(Please delete as appropriate)*	I consent/do not consent to be contacted by SMS on my mobile number. I consent/do not consent to be contacted by email at this address: We may contact you with appointment details, results, health awareness events, etc.		

Special circumstances:	Please tick if any of the following apply to your child: I have a carer I am a carer I have communication difficulties Asylum seeker Housebound Live in a nursing home Live in a residential home Live in a community psychiatric home Live in a children's home		
Height		**Weight**	
Allergies		**Disabilities**	
Is your child: *Registered blind or partially sighted* *Registered deaf* *Registered disabled*		*Please state which of these apply:*	
Please state your child's ethnicity			
Does your child have any drug allergies? *Please include known reactions*			
Does your child have any other allergies? *Please give as much detail as possible*			
Does your child suffer from any of the following: *Asthma* *Depression* *Diabetes* *Epilepsy*		*Please state which of these apply and give date of last review:*	
Does your child have any other serious or chronic illness?		*Please explain:*	
Does your child have a family history of: *Asthma* *Diabetes* *Heart disease* *High cholesterol* *Heart attack* *Stroke* *Cancer* *Liver disease*		*Please give details, including relationship, illness and age at diagnosis, if known:*	

Depression *Epilepsy* *COPD*	
Has your child had any significant injuries or major operations?	If yes, please give details:
Current medication	If possible, attach a copy of your child's repeat prescription list.
Medication	Dosage / Repeat / Quantity remaining

PARENT OR GUARDIAN DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

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 ☐

Please note, it is your responsibility to keep the organisation up to date with any changes to your address, telephone number or email address.

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your child's new patient health check.

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 that 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.

a) **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.

c) **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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, 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: ……

Address: ……

Postcode: …… Date of Birth: ……

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

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.