New Springwells
Springwells, Billingborough, Sleaford, Lincs. NG34 0QQ
Tel. 01529 240234 Fax. 01529 240520

13 – 16 Year Olds New Patient Information Pack

Welcome to the New Springwells Practice

Please find enclosed the following:

1. Registration form (purple)
2. New Patient Health Questionnaire
3. Opt Out Form for the Summary Care Record.
4. Sharing Patient Record Consent Form
5. Health Visitor / School Nurses Information
6. Confidentiality Form
7. 13 – 16 Year Old Letter
8. Personal Information Form

To register at the surgery you will need your NHS Number. This can be obtained from your current surgery, your repeat prescription or on any NHS correspondence that you have received. We cannot register you without this number.

Parents: Please complete the enclosed forms and return them to the surgery with your child's Birth Certificate (if possible we require the Birth Certificate with Parents information on it), Passport if your child has one and your child's Red Book or a list of their completed immunisations

New Patient Medical

- A New Patient Medical is only needed for a child under 5 years old if they are on medication. Please book them in at reception if this is needed when returning the forms.
- If your child is taking medication please bring the prescription list from your previous surgery or the boxes of medication themselves along to this appointment.
- We also require a list of your child's past vaccination history which can be faxed by your previous surgery to us on 01529 240520.

If possible please bring your registration documents into the surgery during our less busy period which is between 2:00pm and 5:00pm.

Useful Information

- Visit our website on www.ruralmedical.co.uk
- When you are registered we can provide you with a password for booking online Doctors appointments and ordering medication.
- The text message consent form provided will allow us to send you a reminder text message whenever you book an appointment.
- We ask that you give dispensary 48 hours notice when ordering repeat medication. Their telephone line is open from 10am – 4pm on direct telephone number: 01529 240888.

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Dear Patient

When you are young, your parents are usually involved in your health care. They may make decisions for you, and speak to health workers on your behalf. But as you get older you have more rights.

You can decide if you want your parents/Guardians to be involved or not.

The enclosed leaflet explains your rights now that you are thought to be old enough to make your own decisions about your health care information. The ICO (information Commissioners Office) suggest that individuals begin to understand their data rights between 12-14 years of age. As such, we would like to support you to be responsible for your health data.

We understand you **may** still wish for your parents to contact the surgery on your behalf at times to obtain information held in your clinical records, such as vaccination history or receive reminders for your appointments, to enable this access to your personal health information you will have to give your consent by filling in the enclosed Confidentiality Form.

Yours sincerely,

Jayne Farrell

Jayne Farrell
Senior Receptionist

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PATIENT / CARER CONFIDENTIALITY FORM FOR 13 TO 16 YEAR OLDS

Dear Patient

The practice is committed to maintaining Patient Confidentiality and will only give information and results to the patient who has had the investigation.
If you would like to give information about your healthcare, for example test results to a relative. Please confirm consent by completing the details below.

YOUR DETAILS

Name: ……...

Date of Birth: …… Telephone Number: ……..

Address: ……...

…… Postcode: ……..

I consent to the following information about my Health Care being given to:

Name: ……...

Relationship to you: ……..

IS THIS PERSON A CARER FOR YOU: YES ☐ NO ☐

What access to your Health Care would you like to give to this person:

All Information: YES ☐ NO ☐

Appointment Details: YES ☐ NO ☐

Results: YES ☐ NO ☐

Medication Details: YES ☐ NO ☐

Consultations: YES ☐ NO ☐

Your Signature: ……..

I consent to the following information about my Health Care being given to:

Name: ……...

Relationship to you: ……..

IS THIS PERSON A CARER FOR YOU: YES ☐ NO ☐

What access to your Health Care would you like to give to this person:

All Information: YES ☐ NO ☐

Appointment Details: YES ☐ NO ☐

Results: YES ☐ NO ☐

Medication Details: YES ☐ NO ☐

Consultations: YES ☐ NO ☐

Your signature: ……

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UPDATE TO PERSONAL INFORMATON FOR 13 TO 16 YEAR OLDS

NAME: ……

DATE OF BIRTH: ……

ADDRESS:

……

…… POSTCODE: ……..

Email Address: ……..

Telephone Details:

Please put down the telephone number(s) that you would like on your record. If you want to put a parent / guardians' number on your record please indicate whose number it is. Please be aware that if you only put down a parent / guardian mobile all text messages will be sent to that mobile.

Telephone Number: …… Whose number is this: ……

Mobile: …… Whose number is this: ……

Mobile: …… Whose number is this: ……

Mobile: …… Whose number is this: ……

Text Messaging:

If you register for text messaging we are able to send a text reminder for any appointments you have booked with us. If you would like to register please fill in the information below.

Mobile Number: …… Whose number is this: ……

Your Signature: ……

Online Access

Online Access is a 24 hour online service that enables you to view, book or cancel appointments.

To register for the online service you will need to fill in the information below and bring a document with your name and address on it.

Yes I would like to register for the online service ☐
No I would not like to register for the online service ☐

Your Signature: ……

(PLEASE TURN OVER)

NEXT OF KIN

NAME: ……..

ADDRESS: ……

…… POSTCODE: ……

TELEPHONE NUMBER: ……

MOBILE: ……

RELATIONSHIP TO YOU: ……

NEXT OF KIN

NAME: ……..

ADDRESS: ……

…… POSTCODE: ……

TELEPHONE NUMBER: ……

MOBILE: ……

RELATIONSHIP TO YOU: ……

Please sign below to confirm all of the above information:

Signature: …… Date: ……

AT THE AGE OF 16 WE WILL SEND OUT FORMS FOR YOU TO FILL IN TO UPDATE YOUR DETAILS AGAIN. BUT IF IN THE MEANTIME YOU WOULD LIKE TO UPDATE ANY OF YOUR DETAILS THEN PLEASE CONTACT RECEPTION.

Are you a Carer?

Do you care for a family member?
You may be supporting a parent, brother, sister, grandparent or any other relative:

* With a physical disability
* With a mental health condition
* With a learning disability
* Who misuses alcohol or drugs
* With a sensory impairment, such as hearing or sight loss
* With a life limiting condition with any other long term illness or condition

Please contact the Practice if you require any further support or information.
You can contact **Lincolnshire Young Carers** by phoning **01522 553275**

School Nursing Team

School nurses are registered nurses with an additional public health qualification. They lead teams Community Registered Nurses and School Nurse assistants to deliver a core programme of services for children and young people of school age (4-19 years).

What do school nurses offer young people aged 11-19?

Transition assemblies to Y7 pupils outlining what they can expect from their school.
HPV programme for Y8 girls. Drop in clinics for pupils, offering for example: support for emotional health and wellbeing, dietary advice and lifestyle choices.
Clinic in a box (sexual health services). This includes C card registration and dispensing (condoms), pregnancy testing, chlamydia screening and provision of the morning after pill. Clinic in a box in delivered in some secondary schools in the drop-in clinic and in some community clinics. School nurses are trained to assess that young people accessing clinic in a box services are safe and protected from abuse.
Sex and Relationships education

School Nurses
Care for Kids

New Springwells

Telephone: 01529 240234

Guide to Accessing Services for Young People Age 13 to 16

Lincolnshire General Practice
All together for a healthier community

Confidentiality

What does confidentiality mean?

It means keeping information safe and private. The practice keeps all your health information confidential. This includes:

* Anything you say
* Information someone writes about you, and
* Details of any treatment you have had

Will my parents be given information about me?

Usually, health workers are not allowed to tell your parents anything you have talked to them about, unless you have agreed to this.

SMOKEFREE NHS

Quit 51 - Call **0800 622 6968**

Text **smokefree** to **66777**

Substance Misuse

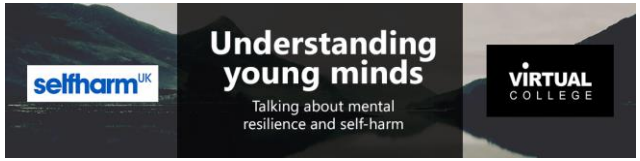
For advice and support with alcohol and substance misuse:

http://www.addaction.org.uk/services/young-addaction-lincolnshire

Tel: **0800 304 7021**

young addaction

Self Harm



Virtual college have donated their time and resources to create a free online course with selfharmuk.

Access your free online course:

www.understandingyoungminds.co.uk

Tel: 01943 885085

kooth

Free, safe and anonymous online support for young people

Tel: 0845 330 7090 **Web:** https://kooth.com/

Bullying

It is bullying if you feel hurt because of things said about your ethnic background, religious faith, gender, sexuality, disability, special educational need, appearance or issues in your family.

If you think you are being bullied, speak with a parent, head teacher or school nursing team.

If you find it difficult to talk to anyone at school or at home, ring **ChildLine** on **freephone 0800 1111**. This is a confidential helpline. If you are hard of hearing you can use **textphone 0800 400 222**. You can also write to **Freepost 1111, London N1 0BR.** The phone call and letter are free.

Kidscape: 08451 205204

Bullybusters: 0800 1696928

Contraception & Sexual Health

Most methods of contraception won't protect you against catching or passing on a sexually transmitted infection (STI). Condoms are the only method that protects against both STIs and pregnancy. Protect your own and your partners health by using condoms as well as your own chosen method of contraception.

To discuss this further or for more information Call **01529 240234 to arrange a routine appointment at the Practice**

The Sexual Health Service provides confidential and non judgemental advice, prevention, diagnosis, treatment and health promotion for all aspects of sexual health.

Sexual Health Services offer free and confidential services including: **STI diagnosis, Testing & Treatment, Chlamydia testing, HIV Counselling and Testing, Contact Tracing. Sexual Health Advice & Information, All Contraception Methods, Emergency Contraception, Pregnancy testing, Termination Counselling & Referral and Free Condoms.**

For availability of Lincolnshire Clinic Sessions, including all appointments and on the day release slots, contact:

Telephone: 01522 309309

www.lincolnshirehealthyfamilies.nhs.uk/sexualhealth

YOUR GUIDE TO SEXUAL HEALTH

Home

Lincolnshire Community Health Services NHS Trust

Summary Care Records

NHS

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:
- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date.....

Sharing Patient Record Consent Form

I have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet “Your Electronic Patient Record & the Sharing of Information”.
I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapist, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

SHARE – OUT (Please tick one of the options below)

I WOULD ☐ I WOULD NOT ☐
like the information recorded at The New Springwells Practice to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data

SHARE – IN (Please tick one of the options below)

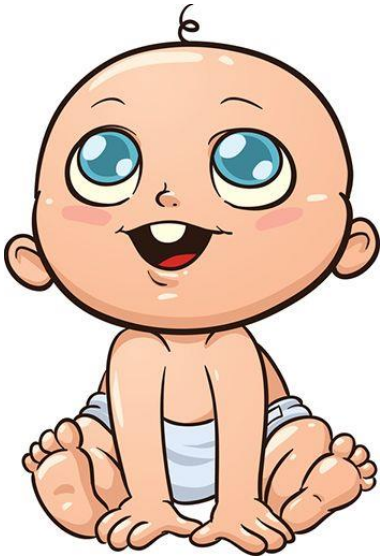
I WOULD ☐ I WOULD NOT ☐
like the information recorded at other care teams who are involved in my care to be seen by members of the team at The New Springwells Practice, where I have granted those core teams the right to add to my shared data.

Patient Name	
Date of Birth	
Signature	
Date	

OR

Patient Name	
Patient Date of Birth	
Patient Representative Name	
Relationship to Patient	
Signature	
Date	

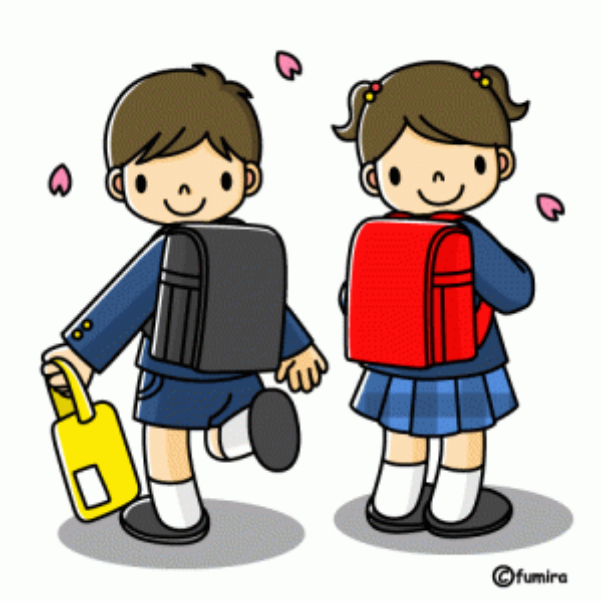
HEALTH VISITOR'S CHILD HEALTH CLINICS 0 – 5 YEARS



Child Health Clinics are held at the surgery every 2nd and 4th Tuesday of each month.

The appointments for the Child Health Clinics are booked directly with the Health Visitor's Team on 01522 843000

SCHOOL CHILDREN



Parents of School Aged Children can contact the School's Nurse

New Patient Health Questionnaire for Children Under 13 Years of Age

Child's Contact Details

Title: Miss ☐ Master ☐ Other ☐

How Many People Live in the Home.....

Home Address .....

.....

.....

.....

Postcode .....

Email: .....

Surname* .....

First Name* .....

Middle Names* .....

Known As .....

Previous Surnames .....

Date of Birth*.....

Home Tel* .....

Parents Mobile* .....

Parents Mobile*.....

Parents / Guardians Information

(If a parent does not have parental responsibility please bring with you the legal document showing this. If you do not present this document we will assume that both parents/legal guardians have parental responsibility If you have the birth certificate that has the parents name on it please bring this with you)

Name of Parent / Guardian .....

If Parent please tick the relationship: Mum ☐ or Dad ☐

Do you have Parental Responsibility Yes ☐ No ☐

Signature .....

Name of Parent / Guardian .....

If Parent please tick the relationship: Mum ☐ or Dad ☐

Do you have Parental Responsibility Yes ☐ or No ☐

Signature .....

Information About the Child

What is the child's height* .....

What is the child's weight* .....

What is the child's first language* .....

Is an interpreter needed* Yes ☐ No ☐

Ethnic Group*

White - ○ British ○ Irish Other (*if other please specify*) .....

Black - ○ Caribbean ○ African Other (*if other please specify*) .....

Asian - ○ Indian ○ Pakistani ○ Chinese Other (*if other please specify*) .....

Mixed - ○ White +Black Caribbean Other (*if other please specify*) .....

○ White + Black African

○ White + Asian

Previous GP

Name of Previous GP* ……..

Address of Previous GP* ……..

…… Postcode ……...

Proof of Identity

○ Birth Certificate ○ Passport ○ Red Book
○ Other (*If other please specify)* …….....

Child's Medical Information

Please list any serious illnesses / operation/ accidents/ disabilities that your child may have / had

……..

……..

If yes, please state the year(s) when your child was first diagnosed: ……

……..

Please list any medicines being taken and the amount: ……

……..

Is your child registered disabled? *(If yes, please give details)* ○Yes ○No

……..

Is your child allergic to any medicines and if so, which? ○Yes ○No

……..

Has your child been refused treatment / screening of any kind if so, what and when? ○Yes ○No

……....

Flu - Chronic disease (e.g. asthma or diabetes)

Has your child had a flu vaccination? ○ Yes ○ No *(if yes enter date)* ……..

Has your child had a pneumococcal vaccination? ○ Yes No ○ *(if yes enter date)* ……

Child's Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer:

……..

……..

……..

Carers

Does your child have a carer? *(If yes please give details)* Yes ○ No ○

……..

Is your child a carer? (If yes please give details) ○ Yes ○ No

Child's Next of Kin

Name of Next of Kin ……

Relationship to you ……

Address ……

…….. Postcode ……

Home Tel …… Mobile ……

Name of Next of Kin ……

Relationship to you ……

Address ……

…….. Postcode ……

Home Tel …… Mobile ……

Contacting You

I agree that I may be contacted from time to time with practice news, advice about my health and / or appointment reminders via.

Email: Yes ○ No ○

SMS Text Messaging: Yes ○ No ○

Online Access

Would you like to register for online access? Online Access allows you to Book or Cancel appointments and order repeat prescriptions online 24 hours a day.

Yes ○ No ○

Signature

Parent / Guardians Signature …… Date:……..

Parent / Guardians Signature …… Date:……..

For Office Use

Checked by: ..... Date: .....

Type of ID photocopied: ..... Proof of Address photocopied: .....

Appointment Booked: .....

Actions to take while registering the patient

Read code: *Patient Allocated Named GP* ☐ *Patient Registered GMS1* ☐ *Informing patient of named GP* ☐
If patient lives in a Care Home ☐ *If consent given for electronic record sharing* ☐ *Donor* ☐ *Text Messaging Consented To* ☐
Text Messaging Declined ☐ *Email Consent Given* ☐ *Email Consent Declined* ☐ *Online Access Consented To* ☐
Online Access Declined ☐ *Next of Kin* ☐ *Parental Responsibility* ☐ *Consent Given for Electronic Record Sharing* ☐

Other Actions: *Text Messaging, Tick Put in Box* ☐ *Online Access* ☐ *Next of Kin to Family Relationships* ☐
Please pass to Jayne if patient is a carer ☐ *or is cared for* ☐ *If patient is over 75 send over 75 letter* ☐
if the patient has signed the donor section please put Lloyd George in the donor envelope ☐
If the patient is under 5 years of age photocopy GMS1 form and put in the under 5's envelope ☐