Review Date: 02/05/18
Jayne Farrell

Under 13's 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

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.

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* .....

Mum's / Dad's Mobile* .....

Mum's / Dad's 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 ☐