Ibstock & Barlestone Surgeries
Traditional Values, Modern Healthcare

New Patient Questionnaire - Child

Welcome to Ibstock & Barlestone Surgeries.
*** Please complete a 'New Patient Questionnaire' for each child (0 – 10 years) in your family.***

Section 1 – Patient Details:

Title:		**First name:**		**Surname:**	

Date of Birth:		**NHS number:** (if known)	

Ethnic Origin: (please tick one)

- ☐ White British
- ☐ White Irish
- ☐ White (Other) …………………………………….………

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Other mixed background ……………………………

- ☐ Caribbean
- ☐ African
- ☐ Black British
- ☐ Black (Other) ……………………………………..…

- ☐ Asian
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Asian (Other) …………………………..…………

- ☐ Other …………………………………………………

- ☐ Prefer not to say

First Language: ……………………………………..………

Do you require the help of a Translator / Interpreter?
(please tick one) Yes / No

Home telephone number:	
Do you consent for the Practice to leave answerphone messages? (please circle one)	Yes / No
Mobile number:	
Do you consent for the Practice to send you SMS messages? (please circle one)	Yes / No
E-mail address:	
Do you consent for the Practice to send you e-mail messages? (please circle one)	Yes / No

Next Of Kin:		**Relationship:**	
Contact details:			

Are you adopted? (please circle one)	Yes / No

Do you have a carer? (please circle one)	Yes / No
If yes, please provide the following information: **Name:** ………………………………………………………………………..……………… **Contact details:** …………………………………………..………………………………	
Do you consent to your information being shared with your Carer?	Yes / No

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If you are applying on behalf of a child who is in foster care / residential care / kinship care etc. or who is not your child please complete the questions below, otherwise please continue to Section 2.

Please note that sufficient evidence will be required to confirm the child's care arrangements, please could we ask you to provide this when registering the child.

Please provide details of the person(s) who can consent to medical treatment for the child and has legal responsibility:	
Name: ……………………………………………………….	**Name:** ……………………………………………………….
Relationship: ………………………………………………..	**Relationship:** ………………………………………………..
Contact details: ……………………………………………….	**Contact details:** ……………………………………………….

Please state the agreed arrangement between the person(s) listed above and the child: (please tick one)

- ☐ Interim Care Order
- ☐ Care Order
- ☐ Child Arrangement Order / Residence Order
- ☐ Special Guardianship Order
- ☐ Section 20 – Voluntary Care
- ☐ Placed for adoption
- ☐ Private arrangement / Private fostering / Informal Arrangement
- ☐ Other ………………………………………….

Section 2 – Family History and Allergies / Sensitivities / Intolerances

Have any of your immediate relatives had any of the following?
If yes, please specify the following: type of diagnosis, their relationship to you and the age they were diagnosed.

- ☐ Blood disorder ……………………………………………………………………………………………
- ☐ Heart condition ……………………………………………………………………………………………
- ☐ Heart Attack ………………………………………………………………………………………………
- ☐ Cancer ……………………………………………………………………………………………………..
- ☐ Diabetes ……………………………………………………………………………………………………
- ☐ High cholesterol …………………………………………………………………………………………..
- ☐ Glaucoma ………………………………………………………………………………………………….
- ☐ Deep Vein Thrombosis (DVT) ……………………………………………………………………………...
- ☐ Epilepsy …………………………………………………………………………………………………….
- ☐ Kidney Disease ……………………………………………………………………………………………..
- ☐ Mental Health problem ……………………………………………………………………………………...
- ☐ Asthma ……………………………………………………………………………………………………….
- ☐ Respiratory condition ……………………………………………………………………………………..
- ☐ Stroke / Transient Ischaemic Attack (TIA) …………………………………………………………………..
- ☐ Other (please specify) ...………………………………………………………………………………….....

Do you have any allergies / sensitivities / intolerances that you know of? (including medications, dressings etc) **If yes, please specify:** ……………………………………………………………………..… ………………………………………………………………………………………………………	Yes / No

Are you taking any current medication? **If yes, please specify:** …………………………………………………………………….. ……………………………………………………………………………………………………… *If you are, please ensure you have 1 month's supply of medication from your current GP Practice before registering.*	Yes / No

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Section 3 – Lifestyle

Height: (m)		**Weight:** (kg)	

Section 4 – Specific Needs

Do you have any sensory impairment? (i.e. speech, hearing, sight) (please circle one) **If yes, please specify:** ………………………………………………………………………………	Yes / No

Are you an 'Assistance Dog' user?	Yes / No

Do you have any physical disabilities that may prevent you from accessing the Practice premises? **If yes, please specify:** ………………………………………………………………………………	Yes / No

Do you have a named Social Worker? (please circle one)	Yes / No
If yes, please provide the following information: **Name:** …………………………………………………………………………………………… **Contact details:** …………………………………………………………………………………	

Section 5 – Your Named Accountable GP / Health Visitor

Under the terms of the latest GP Contract, all patients must have a Named Accountable GP. Having a Named Accountable GP does not prevent you from seeing any other GP in the Practice. If you're Named Accountable GP is unavailable and you require urgent medical attention you may need to discuss this with another GP. Please note that your medical records are available to all the GPs in the Practice. Should you wish to change your Named Accountable GP; the Practice will make reasonable efforts to accommodate this request.	Your Named Accountable GP is: **Dr C Luke**

At Ibstock & Barlestone Surgeries we have an agreement with Community Health Services that incorporates a Children's Health Visiting and School Nursing Liaison service, whereby a Health Visitor is allocated and based at the Practice. The Health Visitor's contact details are below: **Base:** Ibstock Surgery **Telephone number:** 01530 264 928 The School Nursing Services' details are below: **Base:** Ashby Hospital **Telephone number:** 01530 566911	Your Health Visitor is: **Helen Stamp**

Your name:		**Relationship to patient:**	
Your Signature:		**Date:**	

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New Registration – Health Visitor

Welcome to Ibstock & Barlestone Surgeries.
*** Please complete a 'New Registration' for each child in the family.***

Section 1 – Patient Details:

Title:		**First name:**		**Surname:**	

Date of Birth:		**NHS number:** (if known)	

Address:		**Previous address:**	

School attending:	

Parent / Guardian / Carer 1	**Parent / Guardian / Carer 2**
Name:	**Name:**
Relationship to patient:	**Relationship to patient:**
Date of Birth:	**Date of Birth:**
Address: (if different to patient's)	**Address:** (if different to patient's)
Home telephone number:	**Home telephone number:**
Mobile number:	**Mobile number:**
E-mail address:	**E-mail address:**

Section 2 – GP Practice details

GP Practice:	Ibstock Surgery
Address:	132 High Street Ibstock Leicestershire LE67 6JP
Telephone number:	010530 263467
Named Accountable GP:	Dr S Johri

Previous GP Practice:	
Address:	
Previous Health Visitor:	

Your name:		**Relationship to patient:**	
Your Signature:		**Date:**	

Thank you for completing this Registration form.

By signing this form you are agreeing for your child's information to be shared with the Health Visitor and School Nursing Service (if of school age).

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Summary Care Record Consent Form

Summary Care Record Consent Options:

Consent (please tick one)

☐ I consent for my medications, allergies and adverse reactions to be included in my Summary Care Record

OR

☐ I consent for my medications, allergies and adverse reactions AND additional information to be included in my Summary Care Record

Dissent

☐ I DO NOT wish to have a Summary Care Record

Patient Details:

Title:		**First name:**		**Surname:**	

Address:	

Date of Birth:	

If you are completing this form for yourself please complete Part 1.
If you are completing this form on behalf of another person or child, please complete Part 2.

Part 1 – Patient Signature:

Patient Signature:	
Date:	

Part 2 – Your Signature:

Your name:	
Relationship to patient:	
Your Signature:	
Date:	

Please see overleaf for information regarding the Summary Care Record.

Summary Care Record (SCR)

What is a Summary Care Record (SCR)?

The Summary Care Record is a ‘short summary’ of your GP medical record which includes:
- medications;
- allergies;
- adverse reactions.

This is automatically generated when you register at a GP Practice.

Why do I need a Summary Care Record (SCR)?

As well as at your GP Practice, the Summary Care Record can be used by other NHS organisations such as A&E, Out of Hours / NHS 111 and Pharmacies.
Due to these organisations not having access to your full GP medical record, being able to view your SCR may enable them to treat you more efficiently.

Consent to sharing my Summary Care Record (SCR).

Other NHS organisations will ask for your consent before viewing your SCR. In an emergency, if you are unable to provide consent, for example if you were unconscious, your SCR can still be viewed but only by health and care staff with the right levels of security clearance, so your information is secure.

SCR – Additional Information:
You can also consent to including ‘additional information’ into your SCR which includes:
- diagnoses;
- current problems and issues;
- vaccinations;
- consent and personal preferences;
- details of your care professionals / carers;
- care plan events;
- social and personal circumstances.

If you wish to have an SCR, with or without the additional information, you can ‘consent’ by completing the form overleaf.

Dissent to sharing my Summary Care Record (SCR).

If you do not wish for your SCR to be shared with other NHS organisations, you can ‘opt out’ by completing the form overleaf.

What does it mean if I do not have a Summary Care Record (SCR)?

NHS health and care staff caring for you may not be aware of your medications, allergies and adverse reactions in order to treat you safely.

If you have any queries regarding your Summary Care Record, please do not hesitate to ask us.