Saltscar Surgery

Doctors: O'Flanagan, Smith, Rashid, Atxa and Nair
Saltscar Surgery • 22 Kirkleatham St. • Redcar • TS10 1UA
Tel: (01642) 471388 • **Fax:** (01642) 488701
Web: www.saltscarsurgery.nhs.uk

Form **C-u16**

CHILD under-16 Registration Questionnaire

Failure to complete in full may result in non-registration.

Today's Date: _____ Date of birth _____ *(dd/mm/yyyy)*

Forenames: _____ Surname: _____

Address: _____

_____ Postcode: _____

Telephone: *(must complete)*_____ Mobile: _____

Do you consent to receive:

SMS/Text reminders of appointments? *Please tick one:* YES ☐ NO ☐

Email messages: *Please tick one:* YES ☐ NO ☐

Automated voice messages *Please tick one:* YES ☐ NO ☐

Next Of Kin Details:

Full Name: _____

Relationship : _____ (i.e mother/father/spouse)

Address: _____

Telephone: _____ Mobile: _____

Do you have a Carer? *please tick one* YES ☐ NO ☐

(If so please give details)

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Are you the carer for somebody else? YES ☐ NO ☐ *(If YES please give details)*

Name: _____

Address: _____

Telephone: _____ Mobile: _____

Communication:

Do you have any special communication needs due to a disability or sensory loss? For example do you need information in Braille or use British Sign Language to communicate. *Please tell us below:*

_____

_____

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IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORDS
Please read and choose one of the three options. Ask for help from staff if you are not sure.

Do you give permission for the surgery to share your child's information with other Healthcare Providers when you visit them to be seen or if you are admitted to A&E in an emergency?

For more information please read the attached leaflet *Your Electronic Health Record*

Please choose and sign just one option below:

NOTE: If you choose not to specify a preference, the records will *be shared on the grounds of good medical practice.*

Option 1

After reading the above leaflet I am happy for my child's full patient record to be viewed by health and care organisations involved in my care **without an extra verification step**.

Signature: _____ Date_____

Option 2

After reading the above leaflet I DO NOT want my child's patient data to be viewed by **other** health and care organisations involved in my care.

Signature: _____ Date_____

Option 3

I would like to provide an extra security code, or online approval to health and care organisations involved in my care in order to view my child's record.

For this option to work, you must keep your mobile number and email address up to date or have access to your GP online account.

Signature: _____ Date_____

Shared Information options counter-signed by staff:

Signature: _____ Date: _____

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Ethnic Origin: Please Tick One:

White British	
White Irish	
Other White Background	
Black Or Black British Caribbean	
Black Or Black British African	
Other Black Background	
Asian or Asian British Indian	
Asian or Asian British Pakistani	
Asian or Asian Bangladeshi	
Asian or Asian Chinese	
Other Asian Background	
Mixed White and Black Caribbean	
Mixed White and Black African	
Mixed White and Asian	
Other Mixed Background	
Other Ethnic Background	

Main Language Spoken _____ 2nd Language _____

Basic Health: Height: _____ Weight_____

Does your child suffer from any medical Condition?
E.g. Heart disease, high/low blood pressure, Diabetes, Asthma, Arthritis etc.

_____

_____

_____

_____

Has your child had operations or investigations? If so please give approximate dates and details.
Approx. date *Investigation or operation*

_____ _____

_____ _____

_____ _____

_____ _____

Is your child currently under the care of the hospital? If so please give details:

_____

_____

PLEASE REMEMBER TO CONTACT THE HOSPITAL TO INFORM THEM OF YOUR NEW GP.

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Current medications

Please list the names and dosage of your current medication (if any)

Name of medication	*Dosage*	*Name of medication*	*Dosage*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Important Notice: If you are taking any of these medications:

Tramadol, Codeine, Gabapentin, Pregabalin,
Diazepam, Temazepam, Zopiclone, Zolpidem

(or drugs similar to these) by agreeing to be registered at this surgery, you are agreeing to enter any reduction programme the doctor deems necessary.

Do you have any allergies, if so please give details:

_____
_____
_____

Has your mother, father, brother or sister suffered from any of the following?
Please circle yes or no.

Heart disease below the age of 60	YES / NO	Stroke	YES / NO
High blood pressure	YES / NO	Asthma	YES / NO
Diabetes	YES / NO	Glaucoma	YES / NO

Has your child any other medical or social concerns of which you might wish us to be aware?

_____
_____
_____
_____

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What is the NHS Summary Care Record?

The Summary Care Record will contain basic information about any allergies you may have, unexpected reactions to medications and any prescriptions you have recently received. The intention is to help clinicians in Accident and Emergency Departments and 'Out of Hours' health services to give you safe, timely and effective treatment.

Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Children under the age of 16

Patients under 16 years will have a Summary Care Record created for them unless you advise us otherwise on behalf of your child. *If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf.*

If you choose not have to have a Summary Care Record, (although you are strongly recommended to do so), at any time in the future you may change your mind. All you need do is write to the Surgery informing them of your decision to "Opt-In".

Please tick ONE box: I would like to have a Summary Care Record YES ☐ NO ☐

More information can be found at
https://www.nhs.uk/using-the-nhs/about-the-nhs/your-health-records/

Thank you for taking the time to complete our new patient questionnaire.

We may invite you to take a new patient health check.

For office use only – *Admin clerk to confirm each entry is checked and coded*

☐ SMS	☐ Record sharing	☐ NoK
☐ M-jog	☐ Med Hist & Ethnicity	☐ Recoded
☐ SI / SMS Consent	☐ SCR	☐ Tasked to clinician

Input by: _____ Date: _____