NEW PATIENT HEALTH QUESTIONNAIRE

0 - 16 YEARS INCLUSIVE

Castlehead Medical Centre

Ambleside Road, Keswick, CA12 4DB

Tel 017687 72025

PLEASE COMPLETE IN FULL

TITLE	
FIRST NAMES	
SURNAME	
PREVIOUS SURNAME	

ADDRESS **POSTCODE**	
DATE OF BIRTH	**MALE** ☐ **FEMALE** ☐
TEL NO	
WORK NO	
MOBILE NO	
EMAIL	

PARENT /GUARDIAN PARENTAL RESPONSIBILITY NAME (S)	**Name**		**Name**	
	Address		**Address**	
	Date of birth		**Date of birth**	
	Contact number(s)		**Contact number(s)**	
	Relationship to the child			

OVER *13YRS* ONLY DO YOU GIVE CONSENT FOR US TO CONTACT YOU IN THE FOLLOWING WAYS (PLEASE TICK)

HOME TEL ☐ **MOBILE NO** ☐ **LETTER** ☐

DO YOU GIVE US CONSENT TO SPEAK TO YOUR PARENTS/GUARDIAN AS NAMED ABOVE

YES ☐ **NO** ☐

SIGNED_____ **DATE**_____
(child to sign)
(ONLY VALID UNTIL CHILD TURNS 16 YRS)

WHO ELSE LIVES IN THIS HOUSEHOLD	**MUM ☐ DAD ☐ STEP PARENT ☐ PARENTS PARTNER ☐** **GRANDPARENTS ☐ SIBLINGS ☐ HOW MANY? ☐ FOSTER CARER ☐** **GUARDIAN ☐ OTHER PLEASE STATE ……..**

WHO HAS PARENTAL RESPONSIBILITY? PLEASE GIVE US THEIR NAME, CONTACT DEATAILS AND THEIR RELATONSHIP TO THE CHILD (IF NOT GIVEN ABOVE)	

ETHNIC GROUP – WOULD YOU DESCRIBE YOURSELF AS…..	**WHITE ☐ BLACK ☐ ASIAN ☐ MIXED ☐** **BRITISH ☐ CARRIBEAN ☐ INDIAN ☐ WHITE+BLACK CARRIBEAN ☐** **IRISH ☐ AFRICAN ☐ PAKISTANI ☐ WHITE+BLACK AFRICIAN ☐** **CHINESE ☐ WHITE+ASIAN ☐** **OTHER PLEASE SPECIFY ……**
WHAT IS YOUR FIRST LANGUAGE **DO YOU REQUIRE AN INTERPRETER** **DO YOU HAVE ANY COMMUNICATION NEEDS SUCH AS BRAILLE/LARGE PRINT/EMAIL**	 **YES ☐ NO ☐** **PLEASE SPECIFY**
NAME OF PREVIOUS GP	

HAS THE CHILD BEEN OUTSIDE THE UK IN THE LAST 2 YEARS IF SO WHERE AND WHEN	
Is the child a member of a family serving in the Armed Forces? (13WW)	
Is the child a member of a family formerly serving in the Armed Forces? (13WV)	

PROOF OF IDENTITY
BIRTH CERTIFICATE
OFFICE USE ONLY - *IF UNDER 16 YRS AND HAS NO ID REFER TO NHS ENGLAND PATIENT REGISTRATION DOCUMENT*.

IS THE CHILD REGISTERED AS DISABLED	**YES** ☐ **NO** ☐
DOES THE CHILD HAVE LEARNING DIFFICULTIES	**YES** ☐ **NO** ☐ **IF YES PLEASE STATE WHAT THESE LEARNING DIFFICULTIES ARE :**
DOES THE CHILD HAVE A CARER	**YES** ☐ **NO** ☐ **PLEASE GIVE DETAILS**
IS THE CHILD A CARER?	**YES** ☐ **NO** ☐ **PLEASE GIVE DETAILS** **IF YES PLEASE COMPLETE BELOW** **NAME** **ADDRESS** **TEL** **RELATIONSHIP TO CHILD**
DOOR ACCESS KEY CODE - IF APPLICABLE	
WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?	**NAME-** **ADDRESS-** **TEL NO-**
MEDICAL HISTORY	
DOES THE CHILD HAVE ANY KNOWN ALLERGIES (IF YES PLEASE STATE) **DOES THE CHILD HAVE ANY KNOWN DRUG INTERACTIONS (IF YES PLEASE STATE)**	
HAS THE CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS (IF YES PLEASE STATE)	

CURRENT MEDICAL CONDITIONS (PLEASE LIST CONDITION (AND APPROX YEAR DIAGNOSED) DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/ MENTAL HEALTH PROBLEMS/ HEART DISEASE/ HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS	
PLEASE LIST ANY CURRENT MEDICATION FOR THE CHILD NAME/STRENGTH/DOSE	
VACCINATION HISTORY PLEASE LIST ALL KNOWN VACCINATIONS	
WHICH SCHOOL DOES YOUR CHILD ATTEND **NAME** **ADDRESS** **TEL NO**	

DOES THE CHILD HAVE ANY CONTACT WITH THE FOLLOWING?	**A HOSPITAL SPECIALIST** …… **A HEALTH VISITOR** …… **A SOCIAL WORKER** …… **ANY OTHER HEALTH PROFFESSIONALS PLEASE STATE** ……

HAS THE CHILD EVER BEEN UNDER A CHILD PROTECTION PLAN (SOCIAL SERVICES/ SOCIAL WORKER INVOLVEMENT?	**YES** ☐ **NO** ☐ **IF YES PLEASE STATE DETAILS :**

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 normal practice to share the details of all children registering with the practice with our NHS colleagues.
If you would prefer that we DO NOT share this information as described, please tick here. ☐

SIGNATURE OF PERSON WITH PARENTAL RESPONSIBILITY _____

DATE _____

ALL CHILDREN UNDER 16 YEARS WITH ANY PRE-EXISITNG MEDICAL CONDITIONS OR WHO ARE ON ANY REGULAR MEDICATION PLEASE MAKE AN APPOINTMENT WITH A GP.

Your registered GP will be one of the following
Dr D Brigham Dr P Hemingway DR T Hooper Dr A Westwell
Dr K Winterbottom Dr C Ferris Dr C Haslam

Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that

if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record** –. **Please ask GP practice staff for an 'opt out' form, complete the form and hand it to a member of the GP practice staff**.

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) **(01228 602128.),** GP practice staff, or **www.nhscarerecords.nhs.uk** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out.
If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Practice Manager

Castlehead Medical Centre

Prescriptions

If you are taking medication we can send your prescription to a nominated pharmacy for you, or if you live a mile away from a pharmacy you can use our own dispensing facilities. Reception and dispensary staff will be able to advise you if we are able to dispense to you.

It would help us to process your prescription more efficiently if you could please nominate a pharmacy or our own dispensary by indicating below where you would like to collect future prescriptions from (this can be changed at any time by asking our dispensary staff to arrange this for you).

To order repeat prescriptions please either:

- Complete the White Slip showing the list of drugs that you can order as repeat issue.

  Please mark only those items that you need by ticking each item on the White Slip within 5 days of running out.

  Please do not tick items that you do not need.

  You can hand this in to your nominated pharmacy or deliver to the Medical Centre and post in the box by the side of our dispensary
- Call our dedicated Repeat Prescription Line on 017687 80125
- Order on line via our Website www.castlehead.org.uk Once you have registered to access this facility
- Order using the myGP App on your mobile

Please allow at least 48 working hours excluding weekends and Bank Holidays before collection.

……✂……

Please take the completed form to the dispensary

Pharmacy/ Dispensary Nomination

Name ……..

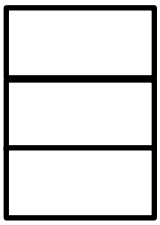
Date of Birth ……..

Address ……..

Castlehead Medical Centre Dispensary

Boots, Main Street, Keswick

Cohens Pharmacy, Station Street, Keswick



Other …… Signature……

Action	Actioned	Date	Action	Actioned		Date
New prescription destination added			Informed about electronic repeat dispensing	Yes	No	
Old nomination removed						
Nominated for EPS prescriptions						

Dr. T. M. Hooper
Dr. K. Winterbottom
Dr. P. E. Hemingway
Dr. Alison E. Westwell

Castlehead Medical Centre
Ambleside Road
Keswick
CA12 4DB
Telephone 017687 72025

CONSENT TO DISCUSS MY MEDICAL INFORMATION

Including 13-16 year olds

(Patient name).....date of birth……..

of address……..

Give my consent to Castlehead Medical Centre to provide my personal medical information to the nominated person(s) named below which must be adequate, relevant not excessive and accurate:

1. Consent given to (name).....

Relationship to me**.....**

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

2. Consent given to (name).....

Relationship to me**.....**

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

If you would like to add any exclusion to this, please list these below, otherwise we will accept this as consent given to discuss or disclose anything in your medical records.

Items to be excluded: ……

……

I understand that this consent form will remain in place until I give written advice to Castlehead Medical Centre to have this withdrawn and I accept that it is my responsibility.

Signed……Date……

Office use only	Date	Initial
Alert added to patient record, including contact tel numbers of 3rd party		
Code added 9NdG		