

**NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE (CHILD)**

**(Revised OCTOBER 2020)**

This information will remain strictly confidential. Please make sure you answer all questions and sign the form.

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| **PATIENT DETAILS**  | **PLEASE COMPLETE IN BLOCK CAPITALS** |
| TITLE: MR/MRS/MISS/MS/DR/OTHER (please state) | SURNAME: |
| FORENAMES: | DATE OF BIRTH: |
| Home Telephone:A landline must be provided if possible.Patients aged between 11-15 will not be given access to on-line appointments and mobile phone numbers for their parents will not be recorded or used as text remindersMobile Telephone: E-mail: |
| If you are registering a child under 18, please state:Mother’s Name: Father’s Name:Mother’s Address: Father’s Address:Contact Number: Contact Number: Please state who has Parental Responsibility Joint/Mother/Father(delete as appropriate)**PLEASE PROVIDE A COPY OF THE CHILD’S IMMUNISATION HISTORY**   |

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| **CHOICES ABOUT SHARING YOUR INFORMATION** |
| **Summary Care Record (SCR):**You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. Your options are outlined below; please indicate your choice by ticking the appropriate box: * **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
* **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
* **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

**Oxfordshire Care Summary:**In addition to the national Summary Care Record, The Oxfordshire Care Summary will allow authorised healthcare professionals involved in your care locally, such as out of hours GPs or hospital doctors, 'view-only' access to more detailed information about your treatment and care. Instant access to reliable health information will help local health care professionals to give you safer, faster treatment.Healthcare professionals must have your permission before they view your Oxfordshire Care Summary, other than in exceptional circumstances such as if you are unconscious.An Oxfordshire Care Summary will automatically be created for you unless you opt put by ticking the box below.* **No – Express dissent for an Oxfordshire Care Record**

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions. |

**Ethnicity**

 White British  White Irish  White Other  Black African  Black Caribbean

 Indian  Pakistani  Bangladeshi  Chinese  Other (please state) \_\_\_\_\_\_\_\_\_\_\_

**What is your first language?**

 English  Other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WILL YOU NEED AN INTERPRETER YES/NO

**Is the child registering a young carer and if so, who do they care for?**

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| Consent for children under 16 (Gillick Competence)Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well. If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.You are free to change your decision regarding your consent choices at any time by informing your GP practice.**SIGNATURE ……………………………………………………………DATE ……………..**Signed by Patient Signed on behalf of Patient |
| **FOR PRACTICE USE ONLY** |
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| **English not first language****Likely to need interpreter** | **Yes/No** |
| **Registration received by Patient Adviser** |  |
| **Completed and signed GMS1 (purple form)** |  |
| **Completed and signed supplementary questionnaire** |  |
| **Copy of immunisation history attached to form** |  |
| **Registration entered on to EMIS** |  |

**NB: If patient has been registered at practice before check reason for returning has** **been supplied.** |