valens
MEDICAL PARTNERSHIP
OUR STRENGTH IS IN OUR CARE

New Patient Questionnaire (Child)

For Office Use Only
ID seen? YES / NO
Patient informed of registered GP? YES / NO

Name of Registered GP:
_____

Welcome to Valens Medical Partnership. Please complete this questionnaire on behalf of the child, as fully as possible. It gives us essential information about their health whilst we are awaiting their medical records.

Date: ……..
Surname: ……
Forename: ……
Name known as: ……
Date of birth: ……
Address: ……
……
……
Postcode: ……
Home telephone number: …… ☐
Mobile telephone number: …… ☐
(Please tick preferred contact number)

Nominated pharmacy for collecting electronic prescriptions:	

If born outside of the UK, please states the date they first entered the UK?: .....

Next of Kin

Should we need to contact you urgently, or in the event of an emergency, we would be grateful if you could provide us with the following details:

Childs Next of Kin: Mr / Mrs / Ms / Other (please state) ……

Name: ……..
Relationship: ……..
Address: ……..
……..
Postcode: ……..
Telephone number (s): Home: ……..
Mobile:……

Important information about repeat medication.

If they are taking regular prescribed medication, please provide us with a copy of their latest repeat medication list. This can be a recent prescription or a medication print-out from their previous practice.
Please note: If repeat medication information is not provided, this may delay their first request for medication.

Have you attached repeat medication information? YES / NO

Ethnicity – What is your ethnic origin? (please tick one box)

White British	□	Indian	□
Other white ethnic group	□	Pakistani	□
Black African	□	Other Asian ethnic group	□
Black British	□	Other ethnic group (please Specify)	□
Black Caribbean / West Indies / Guyana	□		

Main spoken language: ……..
Do you need an interpreter: YES / NO

Smoking

I am a smoker □
(I smoke …..…. per day)
I am an ex-smoker □
(Date stopped ……..)
I have never smoked □

Allergies

Are you allergic to anything (including medicines)? YES / NO

If yes, what are they:
…….....
……
……

If you currently smoke and are interested in quitting, your local Stop Smoking Service can support you. For details go to **www.nhs.uk/smokefree/help-and-advice/local-support-services-helplines.**

Patient Consent

This form will be scanned into their electronic patient record. This information will be used to help the practice provide them with complete and appropriate medical care.
If they leave the practice, this information will be transferred with their medical record to the new practice.
Please sign below to give your consent. If you do not sign to consent, a member of the practice will contact you to discuss your options.

Signature of Parent / Guardian: …..……

Print: …..……

Date: …..……

Summary Care Records / Care Data

Summary Care Records

Valens Medical Partnership has signed up to Summary Care Records. All patients in the Practice will have a Summary Care Record unless they opt out. If you would like any further information regarding Summary Care Records, please visit **http://digital.nhs.uk/scr/patients** or ring **0300 303 5678**. You can also download an 'opt-out' form if required.

Care.data

Under the Health and Social Care Act 2012 the Health and Social Care Information Centre (HSCIC) on behalf of NHS England will be able to extract personal and identifiable information about all patients in England.

What you need to do:

If you are happy for NHS England to direct the HSCIC to extract, store and manage / use their personal information then you need do **nothing** as the information will be automatically taken from our clinical system.

If you don't wish their information to be extracted, then you **MUST** tick the box below and we will then block the uploading of their identifiable and personal information to the HSCIC.

□ I do not agree to the uploading of their identifiable and personal information to the HSCIC.

If you are happy for their information to be extracted and used by the HSCIC for anonymised reports but **NOT** shared by the HSCIC with other agencies or companies in identifiable format, please tick the box below.

□ I do not agree to the sharing of their identifiable and personal information by the HSCIC with other agencies or companies.

Print name: …….

DofB: …….

Signature of Parent / Guardian: …..……

Date: …….