Cumbria Health on Call

Glenridding Health Centre

NEW PATIENT QUESTIONNAIRE (For children up to 16y)

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

Surname: …… Previous Surname/s: ……

First Name: ……

Date of Birth: …… Gender: Male ☐ Female ☐ (Please tick)

Current Address: ……..

…… Postcode: ……..

Please list everyone who lives in this household:

1. Name: …… Relationship to child: ……

2. Name: …… Relationship to child: ……

3. Name: …… Relationship to child: ……

4. Name: …… Relationship to child: ……

5. Name: …… Relationship to child: ……

6. Name: …… Relationship to child: ……

Home Tel: …… Mobile Tel: ……

Email Address: ……..

Who do these details belong to? (eg. Mum, Dad etc.)

Email: …… Home Tel: …… Mobile Tel: ……

Can we leave messages regarding your child on these numbers?

Home Tel: YES ☐ NO ☐ (Please tick)

Mobile Tel: YES ☐ NO ☐ (Please tick)

We often use **SMS** text message to contact patients. Do you want to **OPT OUT**? Please note that this might mean a delay in contacting you. YES ☐ NO ☐ (Please tick)

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WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) and their relationship to the child:

……

……

……

……

Previous Address:

……

……

Previous GP's name and address:

……

……

Health History

Has your child had any serious illnesses or operations? YES ☐ NO ☐ (Please tick)

If Yes, what was this and when?

……

……

Does your child have a disability or chronic condition? YES ☐ NO ☐ (Please tick)

If Yes, please give details and any reasonable adjustments needed:

……

……

Medication

Is your child on any regular medication? YES ☐ NO ☐ (Please tick)

If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy)

……

……

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Is your child allergic to any medication? YES ☐ NO ☐ (Please tick)

If Yes, please state type and name:

……

……

Which school or nursery does your child attend?

……

……

Does your child have contact with any of the following? (If so, please can you tell us their names and contact details)

A hospital specialist: YES ☐ NO ☐ (Please tick) Name: ……

A health visitor: YES ☐ NO ☐ (Please tick) Name: ……

A social worker: YES ☐ NO ☐ (Please tick) Name: ……

Any other health professionals: YES ☐ NO ☐ (Please tick) Name: ……

Has your child ever been under a child protection plan? YES ☐ NO ☐ (Please tick)

Is your child on an early help plan? YES ☐ NO ☐ (Please tick)

If Yes, who is the co-ordinator?

Has your child ever experienced or witnessed domestic abuse? YES ☐ NO ☐ (Please tick)

If so, would you like to access some free recovery work/support for them? YES ☐ NO ☐

(Please tick)

……

Is this child a looked after child? Eg in foster care YES ☐ NO ☐ (Please tick)

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It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS	**DATE GIVEN**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib , rotavirus* age 2m	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, rotavirus* age 3m	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib age 4m	
1st Pneumococcal age 2m	
2nd Pneumococcal age 4m	
1st Meningitis C age 3m	
Hib/ Meningitis C	
1st Measles, Mumps, Rubella (MMR) age 12-13m	
Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio age 3y 4m	
Booster Measles, Mumps, Rubella (MMR)	
Details of any other immunisations:	

* rotavirus included since 2012

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ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete one form for each family member within/joining the practice

NAME _____ DOB _____

What is your main language?

WHAT IS YOUR ETHNIC GROUP?

Choose ONE section from A to F then tick ONE box which best describes your ethnic group or background

Do you need an interpreter or sign language support? Yes ☐ No ☐

A. White	
British	
Irish	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian British	
Pakistani, or Pakistani British	
Indian, Indian British	
Bangladeshi, Bangladeshi British	
Chinese, Chinese British	
Other Asian, please specify:	

D. African	
African, African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean British	
Black, Black British	
Other Caribbean or Black, please specify:	

Other, please specify:

If you would prefer not to provide this information, please tick here:	

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For Internal Use Only:

Practice administration checklist- Surgery to adapt this information as relevant

Identification check

Patients are requested to present 2 forms of I.D. (one being a photograph)
Please tick I.D. checked:

Utility bill / Driving License / Passport / Bus pass / Student I.D. / Other (Please specify)

Date: …….

Surgery to adapt this information as relevant

For Reception Use Only	
• **Form checked and fully completed**	**Yes / No**
• **GMS1 form received and checked**	**Yes / No**
• **Practice Leaflet given**	**Yes / No**
• **ID checked**	**Yes / No – Detail…….**
• **Does patient want online access**	**Yes / No / Proxy**
• **Named GP**	**DR…….**
• **Invite for Health Check with GP to be seen at first encounter appt given**	**Yes / No / Not applicable** **Date…….GP…….**
• **Dispensing patient - YES / NO**	
• **Registration forms sent to HV team if appropriate**	
	Receptionist Name: ……. **Date……**

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For Admin Use Only	
• **GP2GP notes downloaded**	**Yes / No**
• **Registration completed**	**Yes / No**
• **New patient template(Reception Admin) (Ardens V17.1) completed**	**Yes / No** **If Yes, Code all relevant information in template, NOK, lifestyle, family history, Carer, Disabilities etc.**
• **Checked for safeguarding vulnerability**	**Yes / No If yes, send to practice safeguarding team to code, add alerts and send to GP SG lead to review records.**
• **Is patient on repeat medications or have allergies**	**Yes / No If yes, code and document in major alert**
	Admin Name …… **Date……**