NEW CHILD PATIENT HEALTH QUESTIONNAIRE

Please speak to a member of our team if you require this information in a format other than our standard print.

ALL ITEMS ASTERISKED * MUST BE COMPLETED

PLEASE WRITE IN BLACK INK AND USE CAPITALS.

***TITLE:**

○ **MASTER** ○ **MISS** ○ **OTHER**

***GENDER:**

○ **MALE** ○ **FEMALE** ○ **OTHER**

***SURNAME:**

***FIRST NAME(s):**

***DATE OF BIRTH:**

PLEASE USE THIS FORMAT DD/MM/YYYY

***ETHNICITY:**

***FIRST LANGUAGE:**

***ARE YOU NEW TO THE UK** ○ **YES** ○ **NO**

***DATE YOU ARRIVED IN UK**

PLEASE USE THIS FORMAT DD/MM/YYYY

***DO YOU SPEAK ENGLISH** ○ **YES** ○ **NO**

***CAN YOU READ ENGLISH** ○ **YES** ○ **NO**

***DO YOU REQUIRE AN INTERPRETER** ○ **YES** ○ **NO**

***HOME ADDRESS:**

***POSTCODE:**

HOME PHONE NUMBER:

MOBILE PHONE NUMBER:

WORK PHONE NUMBER:

*PLEASE PROVIDE AT LEAST ONE CONTACT NUMBER

EMAIL ADDRESS:

NEXT OF KIN NAME:

FIRST NAMES AND SURNAME REQUIRED

RELATIONSHIP:

I.E. FATHER, MOTHER, BROTHER, SISTER, HUSBAND, WIFE, CHILD.

PHONE NUMBER:

NEXT OF KIN DATE OF BIRTH:

PLEASE USE THIS FORMAT DD/MM/YYYY

NEXT OF KIN HOME ADDRESS:

IF YOU DO NOT HAVE A NEXT OF KIN PLEASE PROVIDE EMERGENCY CONTACT DETAILS:

EMERGENCY CONTACT NAME:
FIRST AND SURNAME REQUIRED

RELATIONSHIP:

PHONE NUMBER:

EMERGENCY CONTACT ADDRESS:

WHAT IS YOUR CURRENT RELIGION, IF ANY:

THERE MAY BE OCCASIONS WHEN WE CORRESPOND WITH YOU BY LETTER.

CAN WE CONTACT YOU BY TEXT ○ **YES** ○ **NO**

CAN WE CONTACT YOU BY EMAIL ○ **YES** ○ **NO**

PLEASE NOTE THAT WE MAY SEND YOU INFORMATION OF A CONFIDENTIAL NATURE USING A SECURE NETWORK. IT IS THE PATIENT'S RESPONSIBILITY TO ENSURE THEIR EMAIL IS PROTECTED FROM MALWARE

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PLEASE INFORM US IF YOU HAVE ANY ADDITIONAL INFORMATION OR COMMUNICATION NEEDS.

KNOWN ALLERGIES:

***IT IS THE PRACTICE POLICY TO SEND PRESCRIPTIONS ELECTRONICALLY TO THE PHARMACY OF YOUR CHOICE. PLEASE PROVIDE YOUR CHOSEN PHARMACY NAME AND LOCATION:**

CHILD HEALTH REQUIRES DETAILS OF ALL IMMUNISATIONS FOR ANY CHILD UNDER THE AGE OF 16 YEARS. THIS INCLUDES CHILDREN THAT HAVE PREVIOUSLY LIVED IN ANOTHER COUNTRY AND ARE NEW TO THE UNITED KINGDOM. PLEASE PROVIDE OFFICIAL, WRITTEN DOCUMENTATION OF ALL IMMUNISATIONS FROM YOUR CARE PROVIDER (HOSPITAL/DOCTOR/HEALTH CLINIC).

***IT IS IMPORTANT THAT THIS INFORMATION IS PROVIDED IN ENGLISH AND IS FROM AN OFFICIAL ORGANISATION. THE PRACTICE CANNOT ACCEPT THIS INFORMATION IN ANY OTHER STANDARD.**

WE RECOMMEND THAT PARENTS/GUARDIANS SIGN THE PATIENT UP TO ON-LINE ACCESS. THIS PROVIDES YOU WITH THE FACILITY OF MAKING/CANCELLING APPOINTMENTS, ORDERING MEDICATION AND VIEWING MEDICAL INFORMATION. PLEASE COMPLETE THE ATTACHED REQUEST FORM TO USE THIS SERVICE. YOU WILL RECEIVE AN EMAIL OR LETTER WITH ACCESS DETAILS ONCE THE ACCOUNT HAS BEEN AUTHORISED.

PATIENTS WITH A SENSORY IMPAIRMENT OR LEARNING DISABILITY WILL HAVE THEIR RECORDS CODED SO THAT WE MAY BETTER COMMUNICATE WITH YOU. PLEASE BE AWARE THAT THIS INFORMATION IS SHARED WITH OTHER CARE PROVIDERS.

PATIENTS THAT WISH TO WITHDRAW THEIR CONSENT TO THEIR CHOSEN FORM OF COMMUNICATION, WILL NEED TO INFORM THE PRACTICE IN WRITING.

***SIGNATURE:**

PARENT/CARER/GUARDIAN

***DATE:**

PLEASE USE THIS FORMAT DD/MM/YYY

Christchurch Surgery
North Street
Downend
Bristol
BS16 5SG
0117 9709 500

Willow Surgery
Hill House Road
Downend
Bristol
BS16 5FJ
0117 9709 500

PATIENT ONLINE ACCESS REQUEST

PATIENT NAME	
DATE OF BIRTH	

I request online access to (please tick where applicable):-

APPOINTMENT BOOKING	
PRESCRIPTION ORDERING	
ACCESS TO DETAILED CARE RECORDS	*For access to your Detailed Care Records please ask a member of our Patient Assistant Team for the relevant Form*

Notice to the Patient:
Some of the information in your medical record written by our GP's and clinical staff may be highly technical and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

It is your choice whether you wish to share your information with others however it is important to understand that it is your responsibility to keep the information safe and secure. Should you wish to provide others with access to your online facilities, you will need to complete a Proxy Access Form, a member of our Patient Assistant Team can provide you with this.

If you think you may be pressured into revealing details from your patient record to someone else against your will then it is best you do not register for access at this time. Please contact the surgery for an appointment with a GP if you feel you are being coerced into sharing your personal information.

For further information on how best to use our online facilities please use the following link: https://www.england.nhs.uk/wp-content/uploads/2016/11/pat-guid-getting-started-gp-online.pdf

I confirm that I have read the above statement and would like Downend Health Group to set up online patient access on my behalf.

Patient Signature ……..

Date ……..

INTERNAL USE

PHOTOGRAPHIC ID PROVIDED?	
PROOF OF ADDRESS PROVIDED?	
ONLINE ACCESS AUTHORISED?	
LOG IN & PASSWORD DETAILS EMAILED?	
Authorisation Date: Staff Name: Position:	