

**MARKET HARBOROUGH & BOSWORTH PARTNERSHIP**

**NEW PATIENT QUESTIONNAIRE**

**\*\*\* FOR CHILDREN 16YEARS OF AGE AND UNDER \*\*\***

Thank you for applying to join Market Harborough & Bosworth Partnership. We would like to gather some information about your child and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give the best possible care.

**Please supply the child's birth certificate or a form of Identification with the completed form, a photographic form of ID (such as passport) and proof of your home address (such as a recent bank statement or document relating to your new home).**

**Please complete all areas in CAPITAL LETTERS and tick the appropriate boxes.**

**Fields marked with an asterix (\*) are mandatory.**

|  |
|--|
| *Title   |
| *Surname   |
| *Home telephone No.<br><br>Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| *Parent / Carer's No.<br><br>Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mobile No.<br><br>Preferred Number <input type="checkbox"/> Yes <input type="checkbox"/> No            |

|                          |
|--------------------------|
| *Date of birth           |
| *First names             |
| *Home Address & Postcode |

|  |
|--|
| Is the child a looked after child? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| *Parental Responsibility – Joint <input type="checkbox"/> Single <input type="checkbox"/> Who?   |
| A child who is being looked after by their local authority is known as a child in care. They might be living: with foster parents, at home with their parents under the supervision of social services or in residential children's homes. |
| <i>Surgery use only – requires appropriate coding &amp; alerts</i>   |

**Staff please check all the form and sign, date and state I.D seen on last page**

**\*School that the child is registered with:**

**I would describe the child's ethnic group as: please tick appropriate box.**

|                            |                          |                                    |                          |                                |                          |
|----------------------------|--------------------------|------------------------------------|--------------------------|--------------------------------|--------------------------|
| British or Mixed British   | <input type="checkbox"/> | Irish                              | <input type="checkbox"/> | Other white background         | <input type="checkbox"/> |
| White & Black Caribbean    | <input type="checkbox"/> | White & Black African              | <input type="checkbox"/> | White & Asian                  | <input type="checkbox"/> |
| Other Mixed Background     | <input type="checkbox"/> | Indian or British Indian           | <input type="checkbox"/> | Other Asian Background         | <input type="checkbox"/> |
| Caribbean                  | <input type="checkbox"/> | African                            | <input type="checkbox"/> | Other Black Background         | <input type="checkbox"/> |
| Chinese                    | <input type="checkbox"/> | Bangladeshi or British Bangladeshi | <input type="checkbox"/> | Pakistani or British Pakistani | <input type="checkbox"/> |
| Other (please state)       |                          |                                    |                          |                                | <input type="checkbox"/> |
| Ethnic Category not stated |                          |                                    |                          |                                | <input type="checkbox"/> |

**Child's Main Language Spoken?**  
(E.g. English)

Name of next of kin \ Emergency contact

Relationship to patient

Next of kin \ Emergency contact telephone number(s)

Next of kin \ Emergency contact address (if different to above)

## Data Sharing

### **Summary Care Record (SCR)**

The SCR is an electronic record summary held on the central NHS database. It provides authorised care professionals with faster, secure access to essential information about you when you need care i.e. medications you are currently receiving.

More information can be found by visiting: <http://systems.digital.nhs.uk/scr>

**Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian completes an opt out form on their behalf requesting us to consider opting them out.**

*If you wish to opt your child out please speak to registrations.*

### **Risk Stratification Preferences**

Risk stratification is the process of identifying the relative risk of patients in a population by analysing their medical history. It's a key enabler for improving the quality of care delivered by the NHS. Market Harborough & Bosworth Partnership is taking part in the Risk Stratification programme and will be uploading patient identifiable data for analysis. Patient identifiable information will only be viewable at GP practice level. Any NHS organisation external to the practice using risk stratification will only see anonymised data.

For more information please visit our website at [www.Marketharboroughmedicalcentre.co.uk](http://www.Marketharboroughmedicalcentre.co.uk)

Tick this box if you wish to opt-out the child of the Risk Stratification programme ( **9nu4**  )

## Carers Information

*A carer is a friend or family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance, but not a wage and the care they are giving will significantly affect their own life.*

Does the child look after or support someone who couldn't manage without them? Yes No

If yes, do they look after someone who is a patient of Market Harborough & Bosworth Partnership ?

Yes No  Don't know

If yes, what is their name?

Are they a: Relative Friend Neighbour

*Surgery use only*

*Patient is a carer 918G  and add details of person cared for to descriptive text box*

Please detail any contact that the child has with other professionals such as health visitors and social workers.

**Medical details**

In order to continue to receive repeat medications you'll need to make an appointment for the child and bring in their last repeat prescription. (Please note, certain medications will require an appointment with the GP before they can be prescribed) Please allow plenty of time to organise repeats.

\*Is the child allergic to any medicines?  Yes  No (if yes please specify)

\*List other allergies / intolerances (i.e. nuts, gluten, pollen, animal hair or certain foods. **Please mark "none" if the child has no other allergies that you know of**)

**Has the child ever had any of the following conditions?**

|                                   |                              |      |  |                                      |                              |      |
|-----------------------------------|------------------------------|------|--|--------------------------------------|------------------------------|------|
| <b>Epilepsy</b>                   | <input type="checkbox"/> Yes | Year |  | <b>Mental Illness</b>                | <input type="checkbox"/> Yes | Year |
| <b>High Blood Pressure</b>        | <input type="checkbox"/> Yes | Year |  | <b>Diabetes</b>                      | <input type="checkbox"/> Yes | Year |
| <b>Heart Attack / Angina</b>      | <input type="checkbox"/> Yes | Year |  | <b>Asthma</b>                        | <input type="checkbox"/> Yes | Year |
| <b>Stroke / Mini-stroke (TIA)</b> | <input type="checkbox"/> Yes | Year |  | <b>COPD (or Emphysema)</b>           | <input type="checkbox"/> Yes | Year |
| <b>Cancer</b>                     | <input type="checkbox"/> Yes | Year |  | <b>Osteoporosis / Bone fractures</b> | <input type="checkbox"/> Yes | Year |
| <b>Rheumatoid Arthritis</b>       | <input type="checkbox"/> Yes | Year |  | <b>Peripheral vascular disease</b>   | <input type="checkbox"/> Yes | Year |

Does the child have any disabilities, illnesses or accessibility needs? i.e. use of a specific communication device such as a hearing aid? If yes, please tell us how we can support their needs.

**The Accessible Information Standard (AIS)**

Please use this space to tell us about any specific communication needs your child may have, ie, needing information in large print or deafblind telephone contact. For further information please visit <https://www.england.nhs.uk/ourwork/accessibleinfo/>

**Does the child have family history of any of the following?**

|  |                              |     |  |                                 |                              |     |
|--|------------------------------|-----|--|---------------------------------|------------------------------|-----|
| <b>High Blood Pressure</b>                               | <input type="checkbox"/> Yes | Who |  | <b>DVT / Pulmonary Embolism</b> | <input type="checkbox"/> Yes | Who |
| <b>Ischaemic Heart Disease Diagnosed aged &gt;60 yrs</b> | <input type="checkbox"/> Yes | Who |  | <b>Breast Cancer</b>            | <input type="checkbox"/> Yes | Who |
| <b>Ischaemic Heart Disease Diagnosed aged &lt;60 yrs</b> | <input type="checkbox"/> Yes | Who |  | <b>Any Cancer Specify type:</b> | <input type="checkbox"/> Yes | Who |
| <b>Raised Cholesterol</b>                                | <input type="checkbox"/> Yes | Who |  | <b>Thyroid disorder</b>         | <input type="checkbox"/> Yes | Who |
| <b>Stroke / CVA</b>                                      | <input type="checkbox"/> Yes | Who |  | <b>Epilepsy</b>                 | <input type="checkbox"/> Yes | Who |
| <b>Asthma</b>  | <input type="checkbox"/> Yes | Who |  | <b>Osteoporosis</b>             | <input type="checkbox"/> Yes | Who |

**If applicable please tell us about the child's smoking habits**

|   |  |
|---|--|
| Does the child smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Is the child an ex-smoker <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, what do you primarily smoke:<br>Cigarettes / E-Cigarettes (please circle)   | When did they quit?<br>How many smoked a day?                                      |
| How many does the child smoke a day?<br>Would they like advice on quitting?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |

Does your child exercise regularly?  Yes  No

**Please record any additional information about your child that you think is important for us to know**

\*Signed:

\*Date

\*Signed on behalf of patient (*if applicable*)  
(e.g. for minors under 16 years old)

Signed .....

Print name.....

Relationship to patient

.....

**Once registered...**

**If there are any problems with your child's registration we will contact you to clarify any issues.**

\*For Surgery use only

DATE.....

STAFF SIGNATURE.....

BIRTH CERT. SEEN  **Or** ADDRESS ID SEEN  TYPE

**Or** RED BOOK SEEN

For surgery use only

ALL CODING & ALERTS FROM FORM ACTIONED

DATE .....

STAFF SIGNATURE .....



**COMMUNITY HEALTH SERVICES – CHILDREN'S  
HEALTH VISITING & SCHOOL NURSING LIAISON**

**New Registration for Children 0-16 Years with the Practice**

Dear Parent / Carer / Guardian

Date \_\_\_\_\_

**Please complete the following details about you family and leave this information at reception. This information will be shared with the Health Visitor (for pre-school children) or the School Nursing Service (if school age).**

Parent / s Name: \_\_\_\_\_

|  |      |                        |  |
|--|------|------------------------|--|
| New Address:   |      | Previous Address:      |  |
| _____  |      | _____                  |  |
| _____  |      | _____                  |  |
| Post Code: _____   |      | Post Code: _____       |  |
| Telephone number home:   |      | Telephone number work: |  |
| Previous GP/Base:  |      |                        |  |
| Child 1:   | DOB: | School:                |  |
| Child 2:   | DOB  | School:                |  |
| Child 3:   | DOB  | School                 |  |
| Registering with GP Name:  |      |                        |  |
| Surgery Address: Market Harborough Medical Centre, 67 Coventry Road<br>Market Harborough. LE16 9BX |      |                        |  |

***Tear off slip for parents below***

|                          |   |
|--------------------------|---|
| Health Visitor Contact : | Cathy Weston, Kellie Vines, Kelsey Smart<br>Tel: 0116 215 6255    |
| School Nurse Contact :   | Cathy Garood, Julie Parker, Sarah Struthers<br>Tel: 0116 215 6265 |