Patient Health Questionnaire for Under 16 years of Age

Orchard Medical Practice
Stockwell Gate
Mansfield
NG18 5GG
Tel: 01623 400100
Fax: 01623 400101
www.orchard-medical.co.uk

Patient Details

First Names: Surname:	Date of Birth:	
Home Address: Postcode:	Home Tel: Work Tel: Mobile: Email:	First Language:
Name & Address of Previous GP:		
Name & Address of Current School:		

Ethnic Group

White	☐ British
	☐ Irish
	☐ Other (please specify)

Black	☐ Caribbean
	☐ African
	☐ Other (please specify)

Asian	☐ Indian
	☐ Pakistani
	☐ Chinese
	☐ Other (please specify)

Mixed	☐ White + Black
	☐ Pakistani
	☐ Chinese
	☐ Other (please specify)

Proof of Identity and Address Provider?

☐ Birth Certificate	☐ Passport	☐ Hospital letter/GP Letter
☐ Child Tax Credit Letter	☐ Child's Red Book	☐ Other (please state) ie, medical card etc

Please provide 2 of the above for each child

Medical Information

Please list any serious illnesses/operations/accidents/disabilities and the year they took place.

Relationship to Child

☐ Parent/Parents (please state parent/parents full names:_____

☐ Guardian

☐ Carer/Foster Parent, please provide proof of responsibility

☐ Other (please state)

Are there any residency orders in place for the child/children you are registering?

Yes/No

If yes please give details: _____

Immunisations

Are you child's vaccinations up to date?

Yes ☐ No ☐

Please could you bring your **CHILDS RED HEALTH RECORD BOOK** at your earliest convenience.

I believe all the information in my new patient health questionnaire to be accurate and correct to the best of my knowledge (please sign and date below when you visit the practice)

Signature: _____ Date: _____

Orchard
Medical Practice

Consent Form

I, _____, have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet "Your electronic patient record & the sharing of information"

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out * Circle your choice

I would* / would-not* like the information recorded at **Orchard Medical Practice** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in * Circle your choice

I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **Orchard Medical Practice** where I have granted those care teams the right to add to my shared data.

I understand that I can change my decision at any time.

Signed

Patient …….. Date Todays date

OR

Patient representative ……

Relationship to patient ……