**Buxted, East Hoathly & Manor Oak Surgeries**

NEW CHILD HEALTH QUESTIONNAIRE

**Name Date of Birth**

It can take some time for your child’s medical records to arrive at the surgery, so it would be helpful if you could complete this questionnaire in the meantime.

Please tick if your child has had the following:

**Developmental Checks by GP/Clinic**

|  |  |  |
| --- | --- | --- |
| 1 | New born |  |
| 2 | 6 – 8 weeks |  |
| 3 | 8 months |  |
| 4 | 24 – 36 months |  |
| 5 | 36 – 48 months |  |

**Immunisation by GP/Clinic**

|  |  |  |
| --- | --- | --- |
| 1 | Diphtheria/Tetanus/Pertussis/HIB/Polio Hep B Men BRotavirus |  |
| 2 | Diphtheria/Tetanus/Pertussis/HIB/Polio Hep BPneumococcal Rotavirus |  |
| 3 | Diphtheria/Tetanus/Pertussis/HIB/Polio Men CPneumococcal |  |
| 4 | HIB/Men C Measles/Mumps/Rubella Men BPneumococcal |  |
| 5 | Pre-school - Diphtheria/Tetanus/Pertussis + Polio MMR |  |

**Is there any family history of: Has your child had:**

|  |  |
| --- | --- |
| Asthma |  |
| Eczema |  |
| Allergies |  |
| Convulsions |  |
| Measles |  |
| Mumps |  |

|  |  |
| --- | --- |
| Asthma |  |
| Eczema |  |
| Allergies |  |
| Diabetes |  |
| Epilepsy |  |

**Which school does your child attend?**

Do you have any worries about your child’s health?

If so, please make an appointment to discuss this with the doctor.

Thank you for taking the time to complete this questionnaire.

Please hand the completed form to one of the Receptionists

|  |
| --- |
| **BUXTED, EAST HOATHLY & MANOR OAK SURGERIES** |

**Consent to proxy access to GP online services**

**Note**: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient’s best interest section 1 of this form may be omitted.

**Section 1**

I,………………………………………………….. (name of patient), give permission to my GP practice to give the following people…………………………………………………………….. proxy access to the online services as indicated below in **section 2**.

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand the risks of allowing someone else to have access to my health records.

I have read and understood the information leaflet “Keeping your online health and social care records safe and secure” – available online at: [www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf)

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 |  |
| 1. Online prescription management
 |  |
| 1. Accessing the medical record for (name of patient)
 |  |

**Section 3**

I/we…………………………………………………………………………….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……… (name of patient).

I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet and agree that I/we will treat the patient information as confidential
 |  |
| 1. I/we will be responsible for the security of the information that I/we see or download
 |  |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our consent
 |  |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential
 |  |

**Note**: For a child, from age 11 you will not be able to have access to their record

|  |  |
| --- | --- |
| Signature/s of representative/s | Date |

**The Patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address Postcode |
| Email address |
| Telephone number | Mobile number |

**The Representatives**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| AddressPostcode | AddressPostcode |
| Email | Email |
| Telephone number | Telephone number |
| Mobile number | Mobile number |

**For practice use only**

|  |  |
| --- | --- |
| The patient’s NHS number | The patient’s practice computer ID number |
| Identity verified by(initials) | Date | Method of verification Vouching Vouching with information in record Photo ID and proof of residence |
| Proxy access authorised by | Date |
| Date account created |
| Date passphrase sent |
| Level of record access enabledProspective RetrospectiveAllLimited partsContractual minimum | Notes/comments on proxy access |

**Summary Care Record Patient Consent Form**

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP Practice:

**Yes – I would like a Summary Care Record**

□ Express consent for medication, allergies and adverse reactions only.

**or**

□ Express consent for medication, allergies, adverse reactions and additional information.

**No – I would not like a Summary Care Record**

□ Express dissent for Summary Care Record (opt out).

Name of Patient: ………………………………………………………………………………………….

Address: …………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ……….................................

Surgery Name:…………………………………… Surgery Location: …………………………

NHS Number (if known): …………………………………………………………………………………

Signature: ………………………………………… Date: ……………………………………………….

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………..............................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney

 for health and welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

You are free to change your decision at any time by informing your GP practice.

**Information for new patients: about your Summary Care Record**

**Dear Patient,**

If you are registered with a GP practice in England you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

**You have a choice**

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.