**Rolle Medical Partnership**
**Patient Health Questionnaire for Children**

## Patient Details

| First Names | Surname | DOB |
|---|---|---|
| | | |

| Home Address …….. | Parent / Guardian Contact Details |
|---|---|
| …….. | Home Tel |
| …….. | Mobile Tel |
| Post Code …….. | Email Address |

**Please tick the box to confirm that you are happy for the Surgery to send you text message reminders regarding appointments, services and practice news.** ☐

## Parental Responsibility

| In case of parents of children who do not live together, who has parental responsibility? | | | |
|---|---|---|---|
| Please tick to indicate | Mother ☐ | Father ☐ | Joint ☐ |

If you have been awarded responsibility via the court please bring a copy of the agreement with you when registering.

## Next of Kin

| Name: | Tel Number: |
|---|---|
| Address: …….<br>……<br>…… | |

## Medical History

| Please answer the following questions in relation to your child's health. | Yes/No | Comments |
|---|---|---|
| Is your child currently awaiting test results from his/her last GP? | | |
| Is your child currently awaiting a Hospital Out Patient appointment or operation arranged by his/her last GP? | | |
| Has your child ever had any operations? If yes, please indicate when these were done and what they were. | | |
| Has your child had any serious illness in the past? If yes, please list. | | |
| Is your child taking any medication at present (including the pill)? If yes, please list. | | |
| Does your child have any drug or other allergies? Please list. | | |
| Does your child care for someone ie a parent, sibling or grandparent? | | |
| Does your child need/have anyone who looks after them or their daily needs as a Carer? The Practice has a dedicated Carers Support Worker who would be pleased to assist – please ask the receptionist for details. | | |
| Does your child smoke? | | |
| If 'no', has he or she ever smoked? | | |
| If your child currently smokes, how many cigarettes or ounces of tobacco do they smoke per week? | | |

**If you have answered yes to any of the above, please make an appointment with your child's new doctor to inform them of the situation.**

## Vaccination History

| | Vaccine | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Tetanus** | **Diphtheria** | **Whooping Cough** | **HiB** | **Polio** | **Meningitis C** | **Pneumococcal** |
| Please tick | | | | | | | |
| Date | | | | | | | |
| | **Measles** | **Mumps** | **Rubella** | **MMR** | | | |
| Please tick | | | | | | | |
| Date | | | | | | | |

## Family History

| Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease and which family member it relates to. | | | |
|---|---|---|---|
| High Blood Pressure | | Diabetes | |
| Heart Disease | | Stroke | |
| Other | | Other | |

## Language & Ethnicity

| What is your first language? | | |
|---|---|---|
| White | ↑British | ↑Irish |
| Black | ↑Caribbean | ↑African |
| Asian | ↑Indian | ↑Pakistani |
| Mixed | ↑White + Black Caribbean | ↑White + Black African |
| | ↑White + Asian | ↑Other (Please state) |

Full Name: …….. DOB: ……..

Signature: …… Relationship to Child**: ……**

## ONLINE SERVICES

Online services are available via our practice Website or an App on your Smartphone. If you would like to sign up to this service for your child please speak to a member of the reception team who can set up access for you. You need to register for this service in person at the practice for this service as your ID will need to be checked. If we are setting up access to your child record your child may need to provide their consent depending on their age.

Benefits to this service include:

- Booking and cancelling appointments with GPs
- Ordering repeat medication
- Viewing your medical records and test results
- Updating your personal details
- Complete questionnaires and ask questions

You can access online services through our website www.rollemedicalpartnership.co.uk or via an app on your smartphone (search for SystmOnline by TPP medical).

# Accessible Information

**If your child requires information in a different format or communication support, please indicate by ticking a box below your preferred format and we will add this to your records.**

| | | | |
|---|---|---|---|
| **Telephone** | | **British Sign Language** | |
| **Letter** | | **Makaton** | |
| **Email** | | **Braille Uncontracted (Grade1)** | |
| **Short Message Service Text Message** | | **Braille Contracted (Grade 2)** | |
| **Via Carer** | | **Written in Large font** | |
| **Loud Verbal Communication** | | **Written in Large font 20 point** | |
| **Text Relay** | | **Written in Large font 24 point** | |
| **Via Telephone Interpreting Line** | | **Written in Large font 28 point** | |

# Patient Consent to Data Sharing

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether or not you wish us to share the information that we have recorded about you within your patient record. For further information on who we share with and what steps we take to protect the information we hold, please see our Fair Processing Notice or Privacy Notice available on our website www.rollemedicalpartnership.co.uk or at the Practice.

If you wish to withdraw your consent from the NHS Digital National Data Extraction please visit the 'Your Data Matters' website www.nhs.uk/your-nhs-data-matters. This is the government data extraction that is used to help design health services of the future and to guide future research. Please note we are not able to change your consent preferences for this in the Practice.

**I give my consent to my child records being shared for the following purposes:-**

Please tick against each data set identifying if you wish or do not wish to share this data

| Record Sharing Initiative | I hereby give consent for my information to be shared. | I do not consent for my information to be shared. |
|---|---|---|
| Summary Care Record<br>(used in health care settings to see your basic health information, medication, major conditions and allergies) | | |
| Local Shared Care Record<br>(local providers only eg other GP Practices) | | |
| Consent for this organisation to view data that is recorded at other care services (other GP Practice you may attend) | | |

Full Name: …….. DOB: ……..……

Signature: …… Relationship to Child**: ……**

## Please note you can amend your consent preferences at any time.