Leatside Health Centre

Patient Questionnaire (Child/Young Person: under 18 years)

Whilst we are waiting for the child's/young person's full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that care is transferred as seamlessly as possible.

- Please complete in **BLOCK CAPITALS** and tick relevant boxes.
- Please complete a separate form for each child/young person to be registered.
- Please bring in evidence of the child's/young person's immunisation record e.g. red book.
- When handing in, please remember to bring photo ID & proof of address of registering adult and proof of ID for the child/young person e.g. birth certificate.

Do you have any special communication needs? Yes ☐ No ☐

If yes, Sign Language ☐ Large Print ☐ Other ☐ please specify _____

Child/Young Person's Personal Details

Child/young person's full name			
Child/young person's date of birth			
Preferred Title e.g. Mr, Miss, Mrs, Mx etc		**If you would like us to record their preferred pronouns, please give details**	
How does the child/young person describe their gender identity? (The answer does not have to match the sex registered at birth)	**Male ☐ Female ☐ Non-binary ☐ In another way ☐**		
Is their gender identity the same as the sex registered at birth?	**Yes ☐ No ☐**		
NHS No (if known)			
Home tel. number			
Mobile tel. number		**Can we contact you by SMS?**	**Yes ☐ No ☐**
E-mail address		**Can we contact you by email?**	**Yes ☐ No ☐**

Name of Parent(s)/Carer(s)	**Relationship to Child/ Young person**	**Has Legal Responsibility?**	**Next of kin?**
1.		**Yes ☐ No ☐**	**Yes ☐ No ☐**
2.		**Yes ☐ No ☐**	**Yes ☐ No ☐**

Name of person(s) with legal responsibility if not parent/carer:	
Name of School/Nursery attended:	
Is child/young person home educated?	**Yes ☐ No ☐**

Please list other household members at your address who are registered with this Practice.

Name	**Date of Birth**	**Relationship**
1.		
2.		
3.		
4.		
5.		
6.		

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Child/Young Person's Medical Background.

Q1: Does the child/young person need help with mobility/communication? **If No, please go to the next question Q2**	**Yes** □	**No** □
Does the child/young person use any of the following mobility/communication aids: **Wheelchair** □ **Walking aid** □ **Hearing Aid** □ **British Sign Language (BSL)** □ **Makaton Sign Language** □ **Lip reading** □ **Large print** □ **Braille** □ **Interpreter** □ **Other** □ **(please specify)**		
Is the child/young person currently housebound?	**Yes** □	**No** □
If the child/young person is housebound, please provide details below:		

Q2: Please give information about any serious illnesses, operations, or injuries the child/young person has had in the past. If none, please go to next question

Condition:	**Year Diagnosed:**	**Ongoing: Yes** □ **No** □

Q3: Please provide details of any medication the child/young person takes (including the contraceptive pill):

Medication Name	**Dosage**	**Frequency**

Q4: Please give details of any allergies or sensitivities the child/young person may have to medication/food:

Q5: Is the child/young person registered with a dentist?	**Yes** ☐	**No** ☐
To find a dentist visit NHS Choices www.nhs.uk		
Q6: Is the child/young person a Looked After Child in the care of the Local Authority?	**Yes** ☐	**No** ☐ **(Go to Q7)**
If yes, in what capacity?	**Permanent** ☐	**Temporary** ☐
Which Local Authority?		
Name of Social Worker:		

Q7: Is the child/young person known to Social Services?	**Yes** ☐	**No** ☐ **(Go to Q9)**
Q8: Is the child/young person or family currently involved with Social Services?	**Yes** ☐	**No** ☐ **(Go to Q9)**
If yes, please give further details, including name of social worker or support worker:		

Q9: Is the child/young person being looked after by a friend, family member, or neighbour in their home (Private Fostering)?	**Yes** ☐	**No** ☐ **(Go to Q10)**
If yes, how long have they been there?		

Q10: Is the child/young person looking after someone at home who is ill, frail, disabled, has mental health/emotional support needs or substance misuse problems?	**Yes** ☐	**No** ☐
If yes, please give details:		
If yes, do you think they would like additional support as a Young Carer?	**Yes** ☐	**No** ☐

Ethnic Group (please select 1):
White - English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Other white background ☐ (please describe)_____
Mixed/Multiple ethnic groups - White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other Mixed/Multiple ethnic background ☐ (please describe) _____
Asian/Asian British - Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background ☐ (please describe) _____
Black/African/Caribbean/Black British - African ☐ Caribbean ☐ Any other Black/African/Caribbean background ☐ (please describe) _____
Other ethnic group - Cornish ☐ Arab ☐ Any other ethnic group ☐ (please describe) _____

Main or 1st language spoken/understood (please select one)

English ☐ Hindi ☐ Gujurati ☐ Urdu ☐ Bengali ☐ Punjabi ☐ Polish ☐ Ukrainian ☐ French ☐ German ☐ Spanish ☐ Other ☐ (please specify) _____

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Religion:
No religion ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations ☐
Buddhist ☐ Hindu ☐ Muslim ☐ Sikh ☐ Jewish ☐
Any other religion ☐ (please describe) _____

Data Sharing and Consent Choices

To maintain continuity of clinical care, we upload certain medical information so that it can be viewed by other healthcare organisations who are directly involved in your care, e.g. hospital Emergency Department. A summary care record (SCR) is an electronic summary of key health information and contains information about your medication, allergies and adverse reactions, and other information such as significant illnesses and health problems, operations and vaccinations. An SCR is automatically created for you, but you can express a preference about what information is included or you can choose not to have one. For more information, visit the website: https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients or speak to a member of staff at the surgery.

For more information about how the surgery handles your personal information, please visit our website and view our Privacy Policy. Alternatively, please speak to a member of staff at the surgery.

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Name of person Completing form: _____ **Date**_____
(Please print)

For Official Use

ID Seen	Birth Certificate ☐
	Passport ☐
	Driving Licence ☐
	Other ☐ Please specify
All required information supplied ☐ Registration accepted ☐ Clinical system updated ☐	
EMIS ID	
Notes:	