Malpas Surgery

Old Hall Street, Malpas, Cheshire SY14 8PS
Tel: 01948 860205 Practice Code: N81038

Partners: Dr Louise M C Davies
Dr Richard W S Henney
Dr Mark R Edney
Dr Christine L Snowden
Mrs Lynn Suckley MBA

NEW PATIENT QUESTIONNAIRE FOR PATIENTS AGED UNDER 16 YEARS

Now that you have registered with our practice your medical records will be forwarded to us from your previous doctor as soon as possible.

However as this process can take quite a time, please complete this questionnaire as fully as possible. The information that you give us will assist us to give you the best possible care.

Personal Details		
Title:	Surname:	Forenames:
Address: Postcode:		
Date of Birth:	Gender: Male [ ] Female [ ] Transgender [ ] Prefer not to say [ ]	
Home Tel No: Parent/Guardian Mobile Tel No: *(To comply with the Data Protection Act we will contact your child 2 months before their 16th birthday to remove the mobile number from their record. They can give us their new mobile number at this point)*	Next of Kin: Relationship: Contact Number: Next of kin Address:	

Consent

We use text messaging for:

- Appointment reminders
- To ask you to arrange follow up blood tests
- To advise you of blood test results
- To send information eg; fit notes, exercise sheets and links to medical information
- Short messages from your Doctor or Nurse

Please tick if you consent to receive text messages for the above. **Consent to receive text messages [ ]**

Ethnicity & Language	
White [ ] Black [ ] Asian [ ] Chinese [ ] Other ……	
What is your first language?	English Yes [ ] No [ ] Other ……..

Disability	
Do you consider yourself to have a disability?	[ ] Yes [ ] No
If yes, details of impairment	Learning disability/difficulty [ ] Mental Health Condition [ ] Other ……

Immunisation History ***(Please tick which immunisations you/your child has had)*** **You can send a copy of the details from your childs Red Book, Child Health Record**			
Immunisation	**Tick**	**Date** *(if known)*	**Comments**
1st Baby Immunisations when 8 weeks+: *(DTaP/IPV/Hib/HepB, MenB, Rotavirus)*			
2nd Baby Immunisations when 12 weeks+: *(DTaP/IPV/Hib/HepB, PCV, Rotavirus)*			
3rd Immunisations when 16 weeks+ *(DTaP/IPV/Hib/HepB, MenB)*			
12 Month Immunisations *(Hib/MenC, PCV booster, MMR, MenB booster)*			
3 years 4 months (Pre-School) *(dTaP/IPV, MMR)*			
Boys and Girls aged 12-13 *(HPV)* - at school			
Boys and Girls age 14 years – School Year 9 *(Td & MenACWY)* - at school			

Medical History (***please tick the medical problems that you have)***			
	Tick	**Details**	**Date (if known)**
Asthma			
Chronic Obstructive Pulmonary Disease (COPD)			
Diabetes			
Heart attack/disease			
Stroke			
Chronic Kidney Disease			
Raised blood pressure			
Cholesterol level over 5.5			
Cancer			
Epilepsy			
Osteoporosis			
Underactive/Overactive Thyroid			
Other serious illness			

Allergies	
Any known allergies?	[ ] Yes [ ] No *If yes, allergic to:*
Details of the reaction	

Repeat Medication	
Are you on any repeat medications?	[ ] Yes [ ] No
Please give us as much information as possible about the medication you are taking. Please tick if you are enclosing a repeat prescription form from your previous surgery.	[ ] Yes [ ] No *If yes, please hand this to reception* *If no, please list below your current medication*

Complete the following with details of ALL medication you are taking
Please include any over the counter medication that you take
There is no need to list the items on your repeat prescription if you are giving us your repeat form.

Name of Medication	**Dosage**	**How often do you take it**	**Reason for using this medication**

All prescriptions are now sent electronically to our dispensary or a pharmacy of your choice.
If you live more than one mile (1.6km) from a chemist, we will dispense your medication from our dispensary. If you live within 1 mile of a chemist we cannot dispense your medication. You can nominate a pharmacy of your choice to collect your prescriptions. Please choose one of the local pharmacies listed below or complete with details of your choice and we will register them on your record.

Local Pharmacies:

Name & Town	**Postcode**	**Please Tick**
Well Pharmacy, Malpas	SY14 8NU	
Rowlands Pharmacy, Whitchurch	SY13 1AX	
Green End Pharmacy, Whitchurch	SY13 1AD	
Boots Pharmacy, Whitchurch	SY13 1DW	
The Pharmacy, Farndon	CH3 6PT	
Well Pharmacy, Tattenhall	CH3 9PX	
Rowlands Pharmacy, Tarporley	CW6 0AB	
Other (please provide name and town & postcode)		

Your prescription will be ready for collection from our dispensary **AFTER 5 working days** from your order being received. Please ensure you have an adequate supply of your medication particularly in the run up to bank holidays when the surgery is closed.

Prescription Charges

A prescription charge will be made for each item purchased unless you fall into one of the exemption categories. We request sight of proof of exemption each time you collect your prescription if you do not pay. Prepayment certificates are available for patients on 2 or more regular medication in each month: please ask for an application form. We accept payment by cash, credit/debit card or cheque.

ALL PATIENTS:

Shared Care Record (SCR)

Malpas Surgery takes part in the data extractions and we want you to have information about this so that you can make a fully informed choice of allowing your data to be shared outside the practice.

You have a choice -

Of what information you would like to share and with whom. Authorised healthcare staff (ie. Consultants in any NHS England hospital) can only view your SCR with your permission. The information shared will solely be used for the benefit of your care. If you do not wish to do so you can "opt out" by ticking the appropriate box. Please be reassured that your access to health care and the care you receive will not be affected by your decision.

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

a) **Express consent for Summary Care Record; medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.

b) **Express consent for Enhanced Summary Care Record; 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.

c) **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, an Enhanced Summary Care Record containing information about your medication, allergies, adverse reactions and additional further medical information will be created for you as described in point b) above.

You are free to change your decision at any time by informing us at the surgery.

Summary Care Record Patient Consent Form

Having read the above information regarding your choices, please choose **one** of the options below by ticking one box:

Yes – I would like a Summary Care Record

[ ] Express consent for Shared Care Record; medication, allergies and adverse reactions only.

or

[ ] Express consent for Enhanced Care Record; medication, allergies & reactions, additional information.

No – I would <u>not</u> like a Summary Care Record

[ ] Express dissent for Summary Care Record (opt out).

Signature: …….. Date: ……

Please bring in a form of photo ID when dropping off your registration forms into the surgery i.e. photo driving license or passport.

Thank you for taking the time to complete this questionnaire.

Office Use Only				
Proof of identity	Passport [ ]	Photo Driving License [ ]		Other:
Proof of address	Utility Bill [ ]	Bank Statement [ ]		Other:
Initials of Staff member			Date	