Malpas Surgery

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

Dr L M C Davies
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NEW PATIENT QUESTIONNAIRE FOR BABIES

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:	

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

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	