Dolphins Practice - Nightingale Primary Care Centre - Butlers Green Road - Haywards Heath - West Sussex - RH16 4BN
Tel: 01444 414767 - Fax: 01444 451532 - www.dolphinspractice.co.uk - e-mail: hsccg.dolphins-haywardsheath@nhs.net

CHILD HEALTH QUESTIONNAIRE

Please complete this form and return to reception

TITLE: Mr/Mrs/Miss/Ms _____ **Date of Birth** _____

SURNAME _____ **First Names** _____

ADDRESS _____

_____ **Post Code** _____

Home telephone no._____ **Mobile Tel no.**_____

NEXT OF KIN
In the case of an emergency only, is there anyone you would like us to contact
Name:
Relationship:
Address:
Telephone numbers – Home:
Mobile:

IMPORTANT

SUMMARY CARE RECORD. Consent given to upload to national shared electronic record YES/NO (if no, please complete separate sheet attached).

0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0

DATE	WEIGHT	HEIGHT

ETHNIC GROUP:

A British/mixed	F White & Asian	K Other Asian	P Other - ethnic
B Irish	G Other mixed	L Caribbean	Q Ethnicity not stated
C Other White	H Indian/British	M African	
D W&B Caribbean	I Pakistani/British	N Other black	
E W&B African	J Bang/Brit Bang	O Chinese	

FIRST LANGUAGE_____

ALLERGIES: Please list below any Medicine, Substance, Food, Animal etc to which you know you have an allergy.

DIET:

A Vegetarian	F High Fibre
B Vegan	G Gluten Free
C Weight reducing	H Low Cholesterol
D Low Fat	I Lactose Free
E Low Salt	J Not on Special diet

FAMILY HISTORY

FAMILY HISTORY Do you have a family history of the following?	**YES/NO**	**Date diagnosed,** if known	**Family member,** i.e.– mother, father, sister, brother, paternal or maternal grandmother/father, aunt etc.
Asthma			
Cancer			
CHD (Coronary Heart Disease)			
CKD (chronic kidney disease)			
COPD (Chronic Obstructive Pulmonary Disease)			
Diabetes			
Diabetes in pregnancy			
Epilepsy			
Heart Disease (Under 60)			
Heart Disease (Over 60)			
Hypertension			
Hypothyroidism			
Mental Health problems			
Stroke or TIA (transient ischaemic attack)			

SMOKING STATUS

Current Smoker	Y / N
EX Smoker	Y / N
Never Smoked	Y / N

DOLPHINS PRACTICE ADVISES A NO SMOKING LIFESTYLE. PLEASE CONTACT RECEPTION IF YOU NEED HELP TO STOP SMOKING.

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Patient Online Access

Access to medical records online includes -

- Making appointments online
- Ordering repeat prescriptions online
- Summary Record (Medication, Allergic reaction and Sensitivities only)
- **Detailed Coded Record

**** If you are requesting access for Detailed Coded Record Access and are a new patient to the Practice this will not be granted for 3 months – due to the fact that we will not have access to your Medical Records in the Practice. If you are an existing patient this can take up to 21 working days and in some circumstances longer.**

For security reasons you will need to provide the following identification:

Passport or Photo Driving Licence

Policy for children 12 years and over

If a child is 12 years of age or over they need to register for online access themselves. Parents will **not** be able to register on their behalf. The child will need their own email address, photo ID/birth certificate and come in person to collect their login details

Children over 12 who wish to have online access will need to be seen by a doctor for them to decide if they feel the child is able to understand a consultation. An appointment will not be made just to discuss this issue.

Please note: **If you are a parent and have access to your child's online account this will automatically expire when your child turns 12 years**.

Patient Online Access: Registration form

Surname			
First name			
Date of birth and age			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Summary Record (Medication, Allergic reaction and Sensitivities only)	☐
**Detailed Coded Record Access	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature…… **Date**……

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Signature of person who verified			Date
Date account created			
Date passphrase sent			

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Dissent from secondary use of patient identifiable data

Dear Doctor,

I am writing to give notice that I refuse consent for my identifiable information and the identifiable information of those for whom I am responsible [*delete as appropriate*] to be transferred from your practice systems for any purpose other than my medical care.

Please take whatever steps necessary to ensure my / our confidential personal information is not uploaded and record my dissent by whatever means possible.

This includes adding the '**Dissent from secondary use of GP patient identifiable data'** code (Read v2: 9Nu0 or CTV3: XaZ89) to my record as well as the '**Dissent from disclosure of personal confidential data by Health and Social Care Information Centre**' code (Read v2: 9Nu4 or CTV3: XaaVL).

I am aware of the implications of this request, understand that it will not affect the care I / we receive and will notify you should I change my mind.

Information to help identify my records [*please complete in BLOCK CAPITALS*]

Title _____ Surname / Family name _____

Forename(s) _____

Address _____

_____

Postcode _____

Date of birth _____

NHS number (if known) _____

Siignature _____ Date _____

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