**Springfields Medical Centre**

**Bath Street Health & Wellbeing Centre Legh Street Warrington WA1 1UG**

**Tel 01925 303250**

**e-mail** **warccg.springfieldsmc@nhs.net**

**website –** [**www.springfieldsmedicalcentre.co.uk**](http://www.springfieldsmedicalcentre.co.uk)

**CHILD QUESTIONNAIRE – FOR CHILDREN UP TO 16 YEARS OF AGE**

**Thank you for applying to join Springfields Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire.**

**Please provide the child’s birth certificate and proof of your home address**

**Name ………………………………………………………. DOB …………………………………………**

**Address ………………………………………………………………………………………………………..**

**…………………………………………………………………. Postcode ………………………………….**

**WHAT IS YOUR CHILD’S ETHNIC GROUP (please circle)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White** | **British** | **Irish** | **Other white (please specify** |  |
| **Black** | **Caribbean** | **African** | **Other black (please specify)** |  |
| **Asian** | **Indian** | **Pakistani** | **Chinese** | **Other Asian****(please specify)** |
| **Mixed** | **White & black Caribbean** | **White & African** | **White & Asian** | **Oher mixed** |

**MAIN SPOKEN LANGUAGE (eg English, British Sign Language (BSL) …………………………………………**

**If you need help with reading/writing please indicate what support you require**

**…………………………………………………………………………………………………………………………………………..**

**British Armed Forces**

|  |
| --- |
| **Is your child a dependant of a current serving member of the British Armed Forces** **YES**  **NO**  |

**Looked after child**

|  |
| --- |
| **A child who is being looked after by their local authority is known as a child in care. They might be living with foster parents, at home with their parents under the supervision of social services pr in a residential children’s home** **Yes No**  |

**If you are applying on behalf of a child who is in foster care/residential care/kinship care/or who is not your child Please tick appropriate box**

|  |  |
| --- | --- |
| **The child is in Foster Care**  |  |
| **The child is in residential care** |  |
| **The child is in Kinship care (looked after by a relative eg grandparent)** |  |
| **Name of Legal Parent or Guardian** |  |
| **The above person can consent for the medical treatment of the child** | **Yes/No** |
| **Other named person can consent for the medical treatment for the child****Please specify name** | **Yes/No** |

**If you are registering a child under 5**

|  |
| --- |
| **I wish the child above to be registered for Child Health Surveillance Yes/No** |

**Carer’s Information**

**A carer is a friend/family member who gives their time to support a person in their home, to an extent that the person could not remain at home if the care was not being provided.**

|  |
| --- |
| **Do you have a carer Yes/No****If yes what is their name(s) and contact number (s)****Do you consent to the carer being informed about the child’s medical care Yes/No** |
| **Does the child look after or support someone who couldn’t manage without them? Yes/No****If yes, do they look after someone who is a patient at Springfields Medical Centre** **Yes/No****If yes, what is their name****Are they a friend/relative/neighbour** |
| **Please detail any contact that the child has with other professionals such as Health Visitors/Social Worker** |

**Next of Kin/Emergency Contact**

**Are the contacts below authorised to discuss the child’s medical record with us Yes/No**

|  |
| --- |
| **Name/Relationship to child/Telephone Number/Address (if different to child)** |
| **Name/Relationship to child/Telephone Number/Address (if different to child)** |

**MEDICATION**

|  |  |
| --- | --- |
| **Does your child take any regular medication? Yes/No****If yes please specify** | **Please attach your repeat medication slip if you have this from your previous GP** |
| **Name** | **Dose (how many tablets per day)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **IS YOUR CHILD ALLERGIC TO ANY MEDICATION YES/NO – if yes please list below** |
|  |
|  |
|  |
|  |

**ALLERGIES**

|  |
| --- |
| **List other allergies/intolerances (pollen, animal hair, food)** |

**SMOKING**

**Does your child smoke Yes/No**

**If yes what do you smoke (cigarettes/pipe/cigar/vape) ……………………………………………………**

**How many do you smoke per day? …………………………………………………………………………………..**

**Would you like advice on quitting Yes/No**

**Are you an ex-smoker Yes/No**

**Approximately when did you quit? ………………………………………………………………………………….**

**EXERCISE**

|  |
| --- |
| **Does your child exercise regularly Yes/No****If yes, what exercise do you take and how often:** |

**COMMUNICATION PREFERENCES**

|  |
| --- |
| **We may want to contact you about your child by e-mail, send appointment reminders to your mobile and leave messages on your answer machine, if you have one****Tick the boxes if you are happy to be contacted****e-mail SMS Answer Machine Letter**[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]**Please tell us which method of contact listed above is preferred …………………………………..** |

**DISABILITY/ACCESSIBLE INFORMATION STANDARD**

|  |
| --- |
| **Please use this space to tell us about any specific communication needs you have ie needing information in large print or deaf/blind. For further information visit** [**https://www.england.nhs.uk/ourwork/accessibleinfo/**](https://www.england.nhs.uk/ourwork/accessibleinfo/) |

**DATA SHARING**

|  |
| --- |
| **SUMMARY CARE RECORD****We would like to recommend that you take advantage of the Summary Care Record (SCR). The core SCR includes important information about your health, medicines you are taking, allergies you suffer from and any bad reactions to medicines****You can also choose to have additional information included in your SCR, which can improve the care you receive. This information includes:-****Your 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****You may need to be treated by Health and Care Professionals outside of the Practice who do not know your medical history. Having the additional SCR can help the staff involved in your care access information more quickly, allowing them to make informed decisions about your healthcare. More information can be found by visiting** [**www.nhscarerecords.nhs.uk**](http://www.nhscarerecords.nhs.uk)**.****Tick this box if you with to OPT IN to the core SCR****Tick this box is you wish to OPT IN to the core and additional SCR****Tick this box if you with to OPT OUT from the SCR** |

**ON-LINE PATIENT ACCESS**

|  |
| --- |
| **Once your application to join our Practice has been accepted you’ll be able to order your repeat medications and book appointments. This service is known as Systmonline. To register for this service please visit,** [**www.springfieldsmedicalcentre.co.uk**](http://www.springfieldsmedicalcentre.co.uk)**, ask reception for an application form or complete the form attached.** **You will need to bring the completed form to reception then you will be given a username and password****Each individual will need their own username and password.** **You will be able to book an on-line TELEPHONE consultation, view and order your medication, view your test results, send the surgery a message.. You can also view your Summary Care Record unless you’ve chosen not to have one. You will also be able to see any allergies recorded, vaccinations, previous illnesses, hospital discharge summaries, appointment letters and referral letters****Ordering Medication on-line****Items that appear on your tick slip and medications that you have had from the surgery in the past will be listed on Systmonline.** **Change of Contact Details****You can update us with your new address, telephone number, e-mail online. You can also consent to receiving text message reminders for things like appointments** |

**HOW TO ORDER YOUR REPEAT MEDICATION**

|  |
| --- |
| **For safety reasons, we do not take prescription requests over the telephone****There are a number of ways you can order your medication:-****On-line via Systmonline (you will need a username and password)****e-mail –** **warccg.springfieldspx@nhs.net****Post your request to Springfields Medical Centre, Legh Street, Warrington WA1 1UG****Complete a prescription request form at the surgery****It takes 48 hours to process your medication. If we receive your request before 4 pm it will be ready within 48 hours after 4 pm.****Your GP will routinely review your medication and may ask you to arrange a review with our Clinical Pharmacist.****If you are due a medication review or health check and fail to attend, we reserve the right to reduce your medication until you have had your review.****Nominated Pharmacy****The majority of prescriptions can be sent electronically to a Pharmacy of your choice. Please let us know your preferred Pharmacy and we can add this to your record.****Any questions regarding ordering your medication, please see our website** [**www.springfieldsmedicalcentre**](http://www.springfieldsmedicalcentre) |