

WATERBEACH SURGERY

NEW BABY HEALTH QUESTIONNAIRE

We would be most grateful if you would complete the following questionnaire for us to update your records. If you are unable, or do not wish to answer any of the questions please leave them blank. This information is confidential and will be seen only by yourself and the practice staff.

Date:.....

Full name Date of Birth

Address.....

Telephone (Home)..... Mobile

Email

Religion.....

Who is the child's main carer?

Who has parental responsibility for the child?

Summary Care Record

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone, which can at times, slow down treatment. Summary Care Records have been introduced to improve the safety and quality of patient care. Because this is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when we are closed.

Your Summary Care Record will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had. It will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you wish to do this, please ask at Reception for an opt out form.

Your Health Record and sharing of information – please read and select your options below.

Your child's health record includes medical history, medication and any allergies you may have. You can now choose whether to share these full medical details. We use a secure electronic health records system called SystemOne. With your permission, this system can allow clinicians to share the record held here with other healthcare services that you may need to use e.g. out of hours services, children's services and community services. These other services will ask your permission to view the record. You have two choices, which allow you to control how your child's record is shared and you can change these choices at any time by letting the relevant practice or service know.

SHARING OUT – This controls whether record information recorded at this practice can be shared with other healthcare service e.g. the out of hours service. Please select one of the options below.

I would like my health record at this practice or service to be shared with other healthcare services providing care for me YES NO

SHARING IN – This determines whether or not this practice can view information in your record entered by other services. Please select one of the options below.

I would like this practice to be able to view information in my health record that has been recorded by other healthcare service. YES NO

MAIN LANGUAGE

Which language is your main spoken language?

ETHNICITY

Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate care, as well as the clinical benefits as some diseases are more common in some ethnic groups.

Please select one of the following

What is your ethnic group?

Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background.

a. White

- British
- Irish
- Scottish

Any other white background, *please write in*

b. Mixed

- White and Black Caribbean
- White and Black African
- White and Black Asian

Any other mixed background, *please write in*

c. Asian or Asian British

- Asian British
- Indian
- Pakistani
- Bangladeshi

Any other Asian background, *please write in*

d. Black or Black British

- Black British
- Caribbean
- African

Any other Black background, *please write in*

e. Chinese and other ethnic group

- Chinese

Any other, *please write in*

FAMILY HISTORY - Do any illnesses run in your family?

Asthma COPD Heart Disease Stroke Diabetes Epilepsy

Is there any family history of:	WHO?	AGE AT ONSET
Hypertension (High blood pressure)
Heart attack/Angina
TIA (Mini Stroke/Stroke)

NEXT OF KIN

Name..... Relationship.....
Address.....
Postcode..... Telephone.....

G/forms etc for printing/newbaby patient history sheet