Main Surgery:
Istead Rise Surgery,
Worcester Close,
Istead Rise,
GRAVESEND,
Kent DA13 9LB
Telephone: 01474 247003
www.downswaymedicalpractice.co.uk

Dr Devinder S Mahil
Dr Tariq S Hussain
Dr Rupal Patel
Dr Reena Jacob
Dr Hajane Jeyabalasingam
Mrs Zara J Williamson
Mr Keith D Fuller

VAT registration No: 879 1358 76

NEW PATIENT HEALTH QUESTIONNAIRE (CHILD AGED 0 – 16 YEARS)

Welcome to Downs Way Medical Practice. As it may take several weeks for your medical records to be transferred from your previous GP surgery, please complete this questionnaire to help us provide you with safe and appropriate care during this period.

Title	Mr ☐ Miss ☐			
First Name				
Surname				
Date of Birth				
Address				
			Postcode	
Who is named on the Birth Certificate for this child	**Mother**		**Father**	
Who else lives in household?	**Mum ☐ Dad ☐ Step Parent ☐ Parents Partner ☐** **Grandmother ☐ Grandfather ☐** **Brothers and Sisters ☐ How many?.....** **Foster Carer ☐ Guardian ☐** **Other – please state……..**			
Home Telephone				
Mobile Telephone				
Email Address				
Who do these details belong to? (Eg Mum Dad etc.)	**Home**			
	Mobile			
	Email			

CONSENT to SMS and EMAIL *(this allows us to send you appointment notifications and general practice information)*	**Please tick** **Yes ☐ No ☐**

Which school or nursery does your child attend?	
Has your child ever been under a child protection plan?	**Please tick** **Yes ☐ No ☐**
Does your child have contact with any other health care or social professional?	**Please tick** **Yes ☐ No ☐** **Details** ……

Health History

Has your child had any serious illness, accidents or operations?	**Please tick** **Yes ☐ No ☐**
If Yes, please give details :	

PLEASE TURN OVER TO COMPLETE SIDE 2

Medication

Is your child on any regular medication?	**Please tick** **Yes ☐ No ☐**
If Yes, please tell us the name and dose :	
Does your child have any allergies?	**Please tick** **Yes ☐ No ☐**
If Yes, please state type and name :	

Immunisations

It is important that your child's immunisations are kept up today. A current photocopy of the immunisation history will help us maintain their immunisation record; we can take a photocopy fo this at reception. If this is not available then please list below

Immunisations	**Yes or No (Please tick)**	**Date given**
8 weeks (1st)	**Yes ☐ No ☐**	
12 weeks (2nd)	**Yes ☐ No ☐**	
16 weeks (3rd)	**Yes ☐ No ☐**	
1 Year old	**Yes ☐ No ☐**	
18 months old	**Yes ☐ No ☐**	
3 year 4 months (pre-school)	**Yes ☐ No ☐**	
12 – 13 years	**Yes ☐ No ☐**	
14 years (year 9 done at school)	**Yes ☐ No ☐**	

Additional Communication Requirements

At Downs Way Medical Practice we want to make sure that we give you information in the way that is clear to you.

Do you have any specific communication needs? Please put a tick in the box that describes your preferred means of communicating.

By phone		**By Letter**	
By Text Message		**Braille Grade 1**	
By Email		**Braille Grade 2**	
Large Print Font		**British Sign Language**	
Easy Read		**Via third party or Carer**	
Do you require the help of a Translator or Interpreter?		**Language** **……**	

Signature

By signing this form I confirm the information provided is correct at the time of submission and confirm that it will be added to my child's medical record.

Signed	
Date	

For Practice Use Only

Date Received	
Date Applied	
Initials	

Application for Online Access

To apply for this service please complete this form and return it to the Surgery in person. You will need to bring photo ID* and proof of address^. You will need an individual e mail address to apply for the service. Registration details will be emailed to you.

Please note they expire one month after issue, so if you haven't activated it by then, you will need to reapply. If you require online access to Detailed Medical Records, ask for the additional form.

**ID needs to show a current photo and signature, eg Current Passport or Driving Licence*
^ Photocopies will be taken and kept on file

Surname	**Date of Birth**
First Name	
Address **Postcode**	
Personal Email address (not shared):	
Home number	**Mobile number**

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my Online Summary (Medications & Allergies) (#93440)	☐

I wish to use Online Services. Please read each statement carefully and tick before signing.

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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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. I agree to be added to the Patient Group to receive information and surveys about the Practice	☐

I understand and agree with all the above statements:

Signature	**Date**

For practice use only

Patient NHS number		EMIS ID number	
Identity verified by (initials)	Date	Method	Vouching ☐ Vouching with information in record ☐ **Photo ID and proof of residence ☐**
Authorised by		Date	