

CONFIDENTIAL PAEDIATRIC MEDICAL HISTORY AND PATIENT CONSENT FORM (CHILDREN UNDER 16 YEARS OLD)



In order to carry out a complete assessment, we require you to complete the following form. Any medical information may be relevant and influence the proposed management of your feet and as such a number of questions are asked about the whole of the body (including medications).

ACCESS TO YOUR RECORDS

You have the right of access to the data that we hold about you and to receive a copy. Parents may access their child's records if this is in the child's best interests and not contrary to a competent child's wishes. Formal applications for access must be in writing to Lucy Rutler.

IF YOU DO NOT AGREE

If you do not wish personal data that we hold about you to be disclosed or used in the way that is described in this Code of Practice, please discuss the matter with your podiatrist. You have the right to object; however, this may affect our ability to provide you with Podiatry care. You have a right to withdraw your consent at any time.

SECURITY OF INFORMATION

Personal data about you is held on a password protected cloud based clinical software system. Medical information can only be accessed by the treating Podiatrist.

WHY DO WE HOLD INFORMATION ABOUT YOU?

We need to keep comprehensive and accurate personal data about patients to provide you with safe and appropriate Podiatry care. We will ask you annually to update your medical history and contact details.

WHAT PERSONAL DATA DO WE HOLD?

To provide patients with a high standard of podiatry care and attention, we need to hold their personal information. This personal data can include:

- Past and current medical conditions; personal details such as age, address, telephone number and general medical practitioner
- Clinical photographs and videos (these are stored on your patient records and used for clinic purposes only)
- Information about their treatment that we have provided or propose and its cost
- Notes of conversations or incidents that might occur for which a record needs to be kept
- Records of consent to treatment
- Any correspondence relating to them and other health care professionals, for example in the hospital or doctors' surgeries.

The information you complete on this form will not be shared with any outside agencies (with the exception of referrals and any reports required in relation to your care, which the Podiatrist will ask for your consent before proceeding) and will be kept in a secure location on the premises.

If you have any questions or concerns about the information you are asked about, please feel free to discuss this with the Podiatrist.

PERSONAL DETAILS

CHILD'S DETAILS

FORENAME(S) SURNAME

DATE OF BIRTH ADDRESS

POSTCODE

PARENT/GUARDIAN CONTACT DETAILS

FULL NAME

RELATIONSHIP TO CHILD

PHONE NUMBER MOBILE NUMBER

EMAIL

GP CONTACT INFORMATION

NAME OF YOUR GP

SURGERY ADDRESS

SURGERY TELEPHONE

MEDICAL HISTORY

Do any of the below apply to the child? If so, please give further details in the space provided at the end of the form.

- | | |
|--|---|
| <input type="checkbox"/> Born before 37 weeks gestation | <input type="checkbox"/> Delayed developmental milestones |
| <input type="checkbox"/> Admitted to Neonatal Intensive care or special care nursery after birth | <input type="checkbox"/> Type 1 diabetes |
| <input type="checkbox"/> Spectrum Condition | <input type="checkbox"/> Type 2 diabetes |
| <input type="checkbox"/> Genetic Condition | <input type="checkbox"/> Hypermobility Spectrum Disorder |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Inflammatory Condition |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Previous nail/ foot surgery | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Skin condition e.g. eczema, psoriasis | <input type="checkbox"/> History of fainting |
| <input type="checkbox"/> Mental Health Diagnosis | <input type="checkbox"/> Previous fractures |
| <input type="checkbox"/> Previous podiatry care | <input type="checkbox"/> Any other health conditions |

Further Details:

Does your child have any allergies/sensitivities?

PODIATRY QUESTIONNAIRE

Please list any sports/ activities in which the child participate, at what level (professional/elite, amateur, hobby) and how frequently? (times per week/month/year)

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.....

Please list any medication taken including herbal, complimentary, vitamin supplements and over the counter medication:

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Please describe your child's problem/ complaint:

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.....

Current shoe size:

Please could you let us know how you heard about us?

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CONSENT

Consent to being treated by a Podiatrist(s)

I understand that the child for whom I have responsibility is to be seen/treated by a Podiatrist. I confirm that I am aware that Podiatrists use sharp medical instruments.

I confirm that I am aware there is currently a Covid-19 pandemic and by being treated there is a small risk of transmission due to mixing with other people. The podiatrist will wear appropriate protective equipment and follow strict infection control protocols to minimise the risk as much as they can. I therefore consent to treatment of the child with this knowledge.

Patient/parent/guardian Name

Patient/parent/guardian Signature **Date**

Relationship to child