SG2 form

Update of Immunisation details and GP details for Child Health

PLEASE WRITE CLEARLY AND IN BLOCK LETTERS (One form per child)

NHS
Oxford Health
NHS Foundation Trust

Following UK Immunisation Schedule? YES / NO (*Please delete*). *If No, please state which country .....*

Name: **Date of birth:**

GP: **NHS number:**

Routine Childhood Immunisations	Age usually given	Date Given (dd/mm/yy)	Indicate if Declined
1st Diphtheria, tetanus, pertussis, polio and Hib	2 months		
Pneumococcal (PCV)			
Meningococcal B Part 1			
Hepatitis B			
Rotavirus			
2nd Diphtheria, tetanus, pertussis, polio and Hib	3 months		
Hepatitis B			
Rotavirus			
3rd Diphtheria, tetanus, pertussis, polio and Hib	4 months		
Pneumococcal (PCV)			
Hepatitis B			
Meningococcal B Part 2			
Hib / Men C (Menitorix)	12 - 13 months		
1st MMR (Measles, Mumps, Rubella)			
Pneumococcal (PCV) booster			
Meningococcal B Part 3			
2nd MMR	3 yrs 4 months approx.		
4th Diphtheria, tetanus, pertussis, polio (Pre-School Booster)			
Human Papillomavirus vaccine (HPV)	12 -18 yrs (♀ only)	1st / 2nd / 3rd	
5th Diphtheria, tetanus, polio (School leavers booster)	13 – 18 years		
Meningitis ACWY			

NON ROUTINE VACCINES	Date given (dd/mm/yy)					BCG Clinical Assessment Outcome	
						Required (meets criteria)	**Not Required** (does not meet criteria)
Mantoux test							
BCG							
Meningitis C						BCG CRITERIA QUESTIONS	
Hib Booster (Haemophilus Influenza B)						• Has the child had a BCG immunisation?	
Flu						• Does the child have a parent or grandparent from a country with high rates of TB, who they have regular contact with?	
Hepatitis B	1st	2nd	3rd			• Was the child born or have they lived in a country with high rates of TB for more than a total of 3 months of their life?	
Neo natal Hepatitis B	1st	2nd	3rd	4th	5th		

Other Vaccines received / Other Information.

Date of Bloodspot Screening Test				Outcome codes
Please enter outcome codes below				**2:** Test declined
Condition	**Code**	**Condition**	**Code**	**4:** Condition not suspected (Normal)
Cystic Fibrosis		MSUD		**5:** Carrier
Hypothyroidism		IVA		**8:** Condition suspected
MCADD		GA1		**9:** Screening incomplete – give details
Phenylketonuria		HCU		**9.1:** Died; **9.2**: Unreliable; **9.3**: Too old; **9.4**: Moved out of area
Sickle Cell				

UNDER 2 years: Neonatal hearing test	Date:

HV/SHN Name..... **Date:**.....

Please return this form to: **Child Health Department, 3rd Floor, The Charter House, Abingdon. OX14 3JY**

Tel No. for Immunisation enquiries:01865 904315

SG1 April 2009

Oxfordshire NHS

Primary Care Trust

INFORMATION FOR CHILD HEALTH SYSTEM

DATE:

Please tick as applicable:

- ☐ Transfer in
- ☐ Labels required
- ☐ Records for archiving
- ☐ Records required (ensure previous details given for transfers in)
- ☐ Change of details (ensure previous details included)
- ☐ Other please specify.....

ALL RECORDS THAT REQUIRE TRANSFERRING OUT OF CASELOAD SHOULD BE SENT VIA CHILD HEALTH DEPARTMENT

☐ Transfer out of Oxfordshire ☐ Complex file requiring transfer by recorded delivery

☐ Transfer within Oxfordshire.

☐ **ALL ELECTRONIC RECORD ENTRIES FOR ALL HV or SHN TEAM MEMBERS ARE DOWNLOADED AND INCLUDED WITH PAPER RECORDS when transferred out or archived**

Contact the named nurse child protection to discuss child protection cases and those with any safeguarding concerns prior to the transfer of records out of Oxfordshire.

Please tick as applicable:

☐ Please contact HV or SHN to discuss further ongoing episode of care or current input.

Contact details.....

☐ All records to be held in Child Health department

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PLEASE TICK BOX TO INDICATE ADDRESS CHANGE PER PARENT/CHILD

Parent/carer details			
Relationship	**Surname**	**Forename(s)**	**Date of Birth**

Childs current details: Surname:		**Previous details:** Surname:	
Forename(s):		Forename(s):	
System No/NHS No	D.O.B	System No/NHS No.	D.O.B
Current Address: Temp/permanent (delete as applicable)		Previous Address: Temp/permanent (delete as applicable)	
Post code:	Tel.No.	Postcode:	Tel No.
Clinic No:	HV No:	Clinic No:	HV No:
GP Name and Surgery:	School/ SH Nurse:	GP Name and Surgery:	School/ SH Nurse:

Please turn over and complete Immunisation Details