COLLINGWOOD HEALTH GROUP – NEW BABY/CHILD (UP TO 16 YRS) PATIENT QUESTIONNAIRE

PATIENT DETAILS	NEXT OF KIN DETAILS
Name:	**Next of Kin**: Relationship:
DoB:	Add:
Tel: (Home)	
Tel: (Mob)	**Contact Number(s) for Next of Kin**:
***Town and Country of Birth**:	(H): (M):

*Nationality and Language (please tick the appropriate box)		
☐ African	☐ Irish	☐ Pakistani or British Pakistani
☐ Bangladeshi or British Bangladeshi	☐ Other Asian Background	☐ White and Asian
☐ British or Mixed British	☐ Other Black Background	☐ White and Black African
☐ Caribbean	☐ Other Mixed Background	☐ White and Black Caribbean
☐ Chinese	☐ Other White Background	☐ Race Not Stated
☐ Indian or British Indian	☐ Other	

THANK YOU