APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE

NHS SCOTLAND

1. PERSONAL DETAILS

Is this your first registration with a GP Practice in the UK? Yes ☐ No ☐

Will you be in the area for more than 3 months? Yes ☐ No ☐

(If 'No', please complete a temporary resident form)

Male * ☐ Female * ☐

Date of birth *

Title *

Surname *

Forenames *

Previous surname *

Address *

Postcode *

Telephone #

Email address #

Mobile #

 # the data supplied in these fields will not be input to, or updated in, the Community Health Index (CHI), but will be held on the GP Practice's system.

The following information can be found on your **current medical card**:

Community Health Index (CHI) number *

NHS number *

The following information can be found on your **birth certificate**:

Town of birth *

Country of birth *

Registered district of birth *(Scotland only)*

Mother's maiden name

2. HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWING INFORMATION

Address in UK when you were last registered with a GP *

Postcode *

Name and address of previous GP Practice in UK *

Postcode *

If you are from abroad:

Date you first came to live in the UK *

If previously resident in the UK, date of leaving *

Your most recent country of residence

If you have served in the British Armed Forces:

Service Number

Enlistment date *

Are you a Reservist? Yes ☐ No ☐

Leaving date *

If yes provide your address before enlisting *

Postcode *

Is this your first registration with a GP since leaving the armed forces? Yes ☐ No ☐

3. VOLUNTARY AUTHORISATION FOR ORGAN OR TISSUE DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.
Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1, including your name, gender, date of birth, address and CHI number.
For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonationscotland.org

Any of my organs and tissue

OR, my:

Kidneys ☐ Eyes ☐ Heart ☐ Lungs ☐ Liver ☐ Pancreas ☐ Small bowel ☐ Tissue ☐

Notes on tissue – Heart valves and corneas come under the 'heart' and 'eyes' boxes respectively so the 'tissue' box covers donating other types of tissue, such as your tendons.

Patient signature Date *

4. HOW WE USE INFORMATION

The information you have provided will be used by NHS Scotland to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.

Your information, including your name, gender, date of birth and address, will be passed to NHS National Services Scotland where it will be held on the Community Health Index (CHI). This information is used to register you with the GP Practice, transfer your medical records between GP practices in the UK, make payments to GP Practices for medical services provided, and to process and issue medical exemption certificates and entitlement cards.

NHS National Services Scotland shares information about you within NHSScotland to assist in the provision and improvement of NHS services and the health of the public. When we do this, we do it as described by NHS Scotland in the NHS Inform website under the "How the NHS handles your personal health information" section.

NHS Scotland is made up of various organisations such as NHS Health Boards, GP practices, the Scottish Ambulance Service or NHS National Services Scotland (the common name of the Common Services Agency for the Scottish Health Service). These organisations are individually responsible for your personal health information. In terms of data protection and privacy laws, they are known as 'data controllers'.

Find out more about NHS Scotland in the link provided above.

5. PATIENT DECLARATION

I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate action may be taken. To enable NHS National Services Scotland to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, the minimum necessary information from this form could be disclosed to relevant authorities.

I understand that more comprehensive information about how NHS Scotland handles my data is available from NHS Inform.

This information can be provided in other languages and formats on request. The NHS Inform helpline provides an interpreting service.

Patient / Patient's representative signature Date *

Representative's name (if applicable)

Relationship to patient (if applicable)

6. FOR PRACTICE USE

GP reference number GP name

Practice code

Mileage (no.) Road Water Footpath

Identification seen – do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of the identification is seen to positively identify the applicant although it is not mandatory to provide identification to register)

Birth cert Student ID card Driving licence Passport or HC2 cert Home Office app reg card Other / None

I accept this patient onto the practice list and declare that, to the best of my knowledge, this information is correct. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be subject to Payment Verification.

Authorised Practice signature Date *

7. FOR OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp

CAIRN MEDICAL PRACTICE

NEW PATIENT REGISTRATION

Surname_____ **Forenames**_____ **Date of Birth**_____

The practice uses SMS as default communication

To opt out of SMS and email communication please tick here ☐

Please help up keep your record up to date by completing the following information:

Why are you leaving your current practice?

I have just moved to the Inverness area ☐
I moved out of my previous practice's area ☐
I was removed from my previous practice's list ☐
Other (please specify):
_____

Ethnic Group

White ☐ Mixed ☐ Pakistani ☐ Bangladeshi ☐ Indian ☐

Caribbean ☐ African ☐ Other: _____

Do you need an interpreter? Yes ☐ No ☐

If yes, which language? _____

Do you drink alcohol? (please tick) Yes ☐ No ☐

How many units of alcohol do you drink each week? _____

For the following questions please tick the most appropriate answer:

How often do you have eight (men)/six (women) or more units on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

How often during the last year have you failed to do what was normally expected of you because of your drinking?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

Has a relative of friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No ☐ Yes, but not in the last year ☐ Yes, during the last year ☐

Smoking status

Smoker ☐ Ex-Smoker ☐ Never Smoked ☐

How many a day?_____

If you are a current smoker support is available to help you stop. Please visit your local community pharmacy for help with this.

Do you exercise regularly? (please tick) Yes ☐ No ☐

How often do you exercise? _____

What type of exercise do you do? _____

Mobility

Are you housebound? (please tick) Yes ☐ No ☐

(Housebound is being unable to leave the house; it is not simply a lack of access to transport.)

We do not have a lift in the practice building. Do you need to be seen downstairs? (please tick) Yes ☐ No ☐

Are you a carer? (please tick) Yes ☐ No ☐

If yes, please provide details: _____

Occupation - Have you every served as a Fire Fighter? (Please circle) Yes ☐ No ☐

Please list any accidents, operations or hospital admissions that you have had in the past:

Did you have a blood transfusion prior to 1996 (please circle) Yes ☐ No ☐

Do you suffer from any medical conditions: e.g. diabetes, asthma etc?

Do you take any of the following?

Prescribed medications: _____

Bought medicines: _____

Herbal remedies: _____

Do you have any known allergies or reactions to medicines?

If so, please specify:

Do you have a Power of Attorney? If so can you provide their name and contact details:

_____

Thank you for taking the time to complete this form. This helps keep your medical record up to date. A full data protection statement can be found on our website