

# K:\My Pictures\Shetland logo.jpg

Scalloway Health Centre

New Road

Scalloway

Shetland

ZE1 0TN

Dr David Sinclair

Dr Chloe Evans

Dr Heather Jamieson

Dr Andrea Gardiner

Dr Margaret Reeves

Phone: 01595 880 219

Fax: 01595 880 461

E-mail: shet.scallowayhealthcentre@nhs.scot

# Welcome to the Scalloway Health Centre

As from the 1st June 2017 the Scalloway Health Centre will be managed by NHS Shetland.

**An appointment system is used for all surgeries and the times are detailed in the Practice Leaflet, which are available at reception.**The above telephone number is the one to use for appointments. After hours an answering machine will give you the number for NHS 24 (111).

Could you please bring one form of photographic identification for your records.

If you are on repeat medication please arrange an appointment with a doctor before ordering your prescription.

It is routine practice for newly registered patient to make an appointment with the practice nurse to have a Well Person Check, please arrange this with the receptionist. It would be helpful if you could bring a sample of urine to your appointment.

Once you have registered with the practice, we will request your records to be passed on from your previous doctor. This can take several weeks.

Yours sincerely

Dr David Sinclair

Dr Chloe Evans

Dr Heather Jamieson

Dr Andrea Gardiner

Enc (5) Registration Form

New Patient Questionnaire

 Ethnic Origin Form

 Envelope for returning forms

 Information Sheet

Scalloway Health Centre

# SURGERY OPENING HOURS

**Mon, Tues, Thurs, Fri 8.30—17.30: Wed 08.30—13.00:**

**To arrange appointments and telephone consultations – telephone 01595 880 219**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **AM** | **DS. MR. AG.** | **HJ. AG.** | **DS. AG. HJ.** | **AG. MR.** | **DS. MR.**  |
| **PM** | **DS. MR.** | **DS. HJ.** | **CLOSED** | **DS. HJ.****DS = David Sinclair HJ = Dr Heather Jamieson** **AG = Dr Andrea Gardiner MR = Margaret Reeves** | **DS. MR** |

**CALLS BETWEEN 8.30 & 9.00 FOR APOINTMENTS ONLY.**

# PRACTICE NURSE CLINICS Mon to Fri 8.30 – 12.45 & 14.00 – 16.45 BY APPOINTMENT ONLY

# HOME VISITS for patients unable to attend the health centre because of illness or disability can be requested by phoning 01595 880219. Please call before 11am.

# ANTENATAL CLINIC

Tuesday - appointment only

Tel: 01595 880 219

# GP & COMMUNITY NURSES OUT-OF-HOURS SERVICES

Between the hours of 5.30pm and 8.30am and at weekends please phone

**NHS 24 on 111** if you require medical attention

You will speak to a trained NHS24 nurse who will arrange the most appropriate service for your current needs. This may range from advice, seeing your own GP the following morning, seeing a GP at the Gilbert Bain Hospital, or a visit by the duty GP.

**Appointment Text Reminder Service**

We provide a text reminder service for appointments booked , please update us with your mobile number if you wish to use this service . If you do **not** wish to use this service please let us know.

**ZET-TRANS DIAL-A-RIDE SERVICES**

There are a number of reserved appointments that can be booked in advance for the weekly Dial-a-Ride Services to the Scalloway Health Centre. Book your appointment at the health centre, and then phone **01595 74 5745** to book the Dial-a-Ride bus at the latest by 16.00 the day before your appointment.

**Weisdale, Whiteness & Tingwall – Thursday mornings**

**To Order Repeat prescriptions**

**Phone 01595 880 690 or on our**

**website—**

**www.scallowayhealthcentre.co.uk/prescriptions1.aspx**

**Please state from which pharmacy you wish to collect your medicines.**

|  |
| --- |
| **Scalloway Health Centre Contact Details** |
| Reception/Appointments/Midwife | 01595 880 219 |
| Repeat Prescription Orders | 01595 880 690 |
| Community Nurses | 01595 880 298 |
| Health Visitor | 01595 880 239 |
| Fax - disabled | 01595 880 461 |
| **Email: shet.scallowayhealthcentre@nhs.scot** |

Please call for **results after 3.00pm**

###### **In an emergency Dial 999**

**Visit the Scalloway Health Centre website at - www.scallowayhealthcentre.co.uk**

**APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE**

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

# PERSONAL DETAILS

Is this your first registration with a Yes No Will you be in the area for more Yes No

GP Practice in the UK? than 3 months?

 *(If ‘No’, please complete a temporary resident form)*

Male \* Female \*

Date of birth \* Address \*

Title \*

Surname \*

Forenames \*

Previous surname \* 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 Mother’s maiden name

(Scotland only)

# HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWINGINFORMATION

Address in UK when you were last registered with a GP \* Name and address of previous GP Practice in UK \*

Postcode \* 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 \* If yes provide your address before enlisting \*

Are you a Reservist? Yes No

Leaving date \*

 Postcode \*

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

 GMSGPPR001 V27 1 2021

# VOLUNTARY AUTHORISATION FOR ORGAN OR TISSUE DONATION

You have a choice about organ or tissue donation after your death. To find out more about why it is important that you take the time to make your donation decision and record it, go to www.organdonationscotland.org

# 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 NHS Scotland 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 com](https://www.nhsinform.scot/care-support-and-rights/health-rights/confidentiality-and-data-protection/how-the-nhs-handles-your-personal-health-information)mon 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.

# 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)

# FOR PRACTICE USE

GP reference number GP name

Practice code

## **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 Home Office Other / None

 HC2 cert app reg card

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 \*

#  FOR OFFICIAL USE ONLY

Practice Stamp

In put by

Checked by

Date

 GMSGPPR001 V27 1 2021

**THE SCALLOWAY HEALTH CENTRE**

**NEW PATIENT QUESTIONNAIRE**

As it will be some time before your old records reach us, it would be helpful if you could answer the following questions on your own or your child’s health.

**NAME:** ……………………………………………………………………………. **DATE OF BIRTH** ...............………………………………………………

Mr/Miss/Mrs

**ADDRESS**: ……………………………………………………………………..... **HOME** **TEL NO**: ………………………………………………………………

…………………………………………………………………………………………. **MOBILE NO**: ..............……………………………………………………

............................................................................................. **TEXT REMINDER SERVICE TO OPT IN PLEASE TICK......**

**MARITAL STATUS**: …………………………………………………........... **TEL NO during office hours**:............................................

**OCCUPATION**: ………………………………………………………….....…. **EMAIL ADDRESS**: ................…………………………………………

|  |  |
| --- | --- |
| Ethnic origin: *Please see last page for details* |  |
|  |
| Are you a carer? YES/NO Does someone care for you? YES/NOWould you be happy for this info to be put on your Record? YES/NOCan we pass your details to other organisations providing local support services and relevant information and advice? YES/NOSignature ………………………………………………………………. Date ………………………………………… |
| Have you suffered from any illnesses in the past? (e.g. heart disease, diabetes, hypertension) | YesYes | No | DateDate | Details |
| Have you had any operations? |  |  |  |  |
| Do you have any allergies? |  |  |  |  |
| Do you have any current health problems? |  |  |  |  |

|  |
| --- |
| FAMILY HISTORYIs there a family history of any particular health problems (e.g. CVA(strokes), diabetes, heart problems, high blood pressure, asthma or any allergies, osteoporosis)……………………………………………………………………………………………………………………………………………………………..……………………………………………………………………………………………………………………………………………………………..**NEXT OF KIN (2)** (One living at the same address and one living at a different address) Name and contact number please........................................................................................................................................................................................................................................................................................................................................ |
| Are you taking any medicines? |
| Name | Name |
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

## **LIFESTYLE FACTORS**

Do you smoke? YES/NO If YES, how many per day? ………………

Have you smoked in the past? YES/NO If YES, how many per day? ………………

When did you stop? ……………………………………

Alcohol consumption:

How many glasses of - wine ………………..……)

 - spirits ………………......) do you drink in an average week?

 (pints) - beer …………………..…)

Do you undertake regular exercise? YES/NO. If YES, please give details and frequency

…………………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………………….

Any problems with hearing/eyesight? ……………………………………………………………………………………….

Do you see a dentist regularly? …………………………………………………………………………………………………..

**ADULT IMMUNISATIONS**

Have you had any of the following immunisations? If you can remember dates, please specify.

|  |  |  |  |
| --- | --- | --- | --- |
| IMMUNISATION | YES | NO | DATE |
| Tetanus |  |  |  |
| Diphtheria & Tetanus |  |  |  |
| Polio |  |  |  |
| Hepatitis A |  |  |  |
| Hepatitis B |  |  |  |
| Typhoid |  |  |  |
| Other (please specify) |  |  |  |

Please return the completed questionnaire in the envelope provided.

Thank you for your help and cooperation.

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your health care, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

Read Codes

(All Chapters)

|  |  |  |
| --- | --- | --- |
| A) White |  |  |
|  | White British | .9s10 |
|  | White Scottish | .9s13 |
|  | White Irish | .9s11 |
|  | Any other white background please write below | .9s12 |
|  |  |  |
| B) Mixed |  |  |
|  | White and Black Caribbean | .9i3 |
|  | White and Black African | .9i4 |
|  | White and Asian | .9i5 |
|  | Any other mixed background please write below | .9sb |
|  |  |  |
| C) Asian or Asian British |
|  | Indian | .9s6 |
|  | Pakistani | .9s7 |
|  | Bangladeshi | .9s8 |
|  | Any other Asian background please write below | .9sh |
|  |  |  |
| D) Black or Black British |
|  | Caribbean | .9s2 |
|  | African | .9s3 |
|  | Any other background please write below | .9sg |
|  |  |  |
| E) Chinese or other ethnic group |
|  | Chinese | .9s9 |
|  | Any other please write below | .9sj |

Please return this form when completed in the enclosed envelope.

Thank you

**Covid 19 Vaccination Status**

Name:…………………………………………………………………………………………

Date of Birth: ………………………………………………………………………………..

Contact Number: ……………………………………………………………………………

Have you received your **first** Covid 19 vaccination? Yes/NO

If yes, when did you receive it? …………………………………………………………

What type of vaccination did you receive e.g. Pfizer, Astra Zenaca, Moderna:

………………………………………………………………………………………………

Have you received your **second** Covid 19 vaccination? YES/NO

If yes, when did you receive it? …………………………………………………………

What type of vaccination did you receive e.g. Pfizer, Astra Zenaca, Moderna:

………………………………………………………………………………………………

Have you received your **booster** Covid 19 vaccination? YES/NO

If yes, when did you receive it? …………………………………………………………

What type of vaccination did you receive e.g. Pfizer, Astra Zenaca, Moderna:

………………………………………………………………………………………………

If you have not previously received a Covid 19 vaccination, would you now like to receive the vaccination? YES/NO

PLEASE RETURN THIS FORM WITH YOUR REGISTRATION PAPERWORK.

Thank you