Scalloway Health Centre
New Road
Scalloway
Shetland
ZE1 0TN

Dr David Sinclair
Dr Heather Jamieson
Dr Andrea Gardiner

Phone: 01595 880 219
Fax: 01595 880 461
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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 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	HJ. AG.	DS. AG.	HJ. AG.	DS. AG.
PM	DS	DS. HJ.	CLOSED	DS. HJ.	DS

DS = David Sinclair **HJ = Dr Heather Jamieson**
AG = Dr Andrea Gardiner

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	01595 880 461
Email—shet-hb.scallowayhealthcentre@nhs.net	

Please call for **results after 2.00pm**

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

1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male* ☐ Female* ☐ 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)

Date of Birth* ☐-☐-☐

Title*

Surname*

Forenames*

Previous Surname*

email address #

Address*

Postcode*

Telephone #

Mobile #

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

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

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:

Enlistment date* ☐-☐-☐

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* ☐-☐-☐

Is this your first registration with a GP since leaving the Armed Forces?* ☐ Yes ☐ No

Service Number

If yes, please provide your address before enlisting*

Postcode*

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 YOUR 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 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 - specify [ ] Receptionist initials [ ]

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. OFFICIAL USE ONLY

Input by [ ]

Checked by [ ]

Date [ ]-[ ]-[ ]

Practice Stamp

Reviewed May 2017

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/NO

Would you be happy for this info to be put on your Record? YES/NO

Can we pass your details to other organisations providing local support services and relevant information and advice?

YES/NO

Signature .... Date ....

	Yes	No	Date	Details
Have you suffered from any illnesses in the past? (e.g. heart disease, diabetes, hypertension)				
Have you had any operations?				
Do you have any allergies?				
Do you have any current health problems?				

FAMILY HISTORY
Is 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

		Read Codes (All Chapters)	
	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