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 *

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 *(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 *

Your most recent country of residence

If previously resident in the UK, date of leaving *

If you have served in the British Armed Forces:

Enlistment date *

Are you a Reservist? Yes ☐ No ☐

Leaving date *

Service Number

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.

Patient / Patient's representative signature Date *

7. FOR OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp

Fairfield Medical Practice

V2018-1

NEW PATIENT QUESTIONNAIRE FOR PATIENTS >12

Surname: _____ **First Name(s):** _____

Date of Birth: _____

REASON FOR JOINING PRACTICE

Geographical Reasons ☐ New to area ☐ Other (please specify): _____

ETHNIC GROUP

White ☐ Pakistani ☐ Bangladeshi ☐ Indian ☐ Caribbean ☐ African ☐ Mixed ☐ Other ☐

IF YOUR FIRST LANGUAGE IS NOT ENGLISH, PLEASE STATE FIRST LANGUAGE: _____

Do you require an interpreter during appointments? **Yes** ☐ **No** ☐

DO YOU REQUIRE INFORMATION/COMMUNICATION SUPPORT? If so, please ✓ below

Blind/Some Visual Loss ☐ Deaf/Some Hearing Loss ☐ Deafblind ☐

Other (please specify): _____

PLEASE SPECIFY THE SUPPORT YOU NEED

British Sign Language ☐ Lip Speaker ☐ Deafblind Communicator ☐

Other (please specify): _____

Do you consent to us sharing your communication needs with Out Of Hours? **Yes** ☐ **No** ☐

NEXT OF KIN DETAILS **Name:** _____ **Relationship:** _____

Address: _____ **Telephone Number:** _____

DO YOU SUFFER ANY OF THE FOLLOWING? Yes ☐ **No** ☐ ***Please state approx. date of diagnosis***

	Stroke	Cancer	Asthma	Epilepsy	Diabetes **1**	Diabetes **2**	Hypothyroid
Date:							

	Heart Problems	Kidney Problems	High Blood Pressure	Lung problems (COPD)
Date:				

ARE YOU RECEIVING TREATMENT FROM ANY SECONDARY CARE DEPARTMENT? Yes ☐ **No** ☐

MEDICATION - DO YOU TAKE ANY OF THE FOLLOWING? If so, please insert the drug names below

Prescribed Medication: _____

Bought Medicines: _____

Herbal Remedies: _____

LIST ANY KNOWN ALLERGIES/REACTIONS TO MEDICINES? If known state date allergy started

_____

FAMILY HISTORY: Do any of your blood relatives have a history of the following conditions?

	✓	Please state family member(s)? i.e. mother/father/grandfather
Asthma		
Diabetes		
High Blood Pressure		
Stroke		
Heart Attack (under 60 years)		
Other – Please state		

Do you smoke? Yes ☐ **No** ☐ If yes how many per day: ☐ If an ex-smoker date stopped: _____

Would you like to be referred for help you stop smoking? Yes ☐ **No** ☐

Do you drink alcohol? Yes ☐ **No** ☐ Units per week: ☐

Weight: _____ Height: _____ Date of last Tetanus vaccine: _____

ARE YOU A CARER? Do you look after someone ***frail, elderly or disabled?*** (Not through work) **No** ☐

Yes ☐ If yes please state **who** you look after and the **reason**: _____

FOR WOMEN ONLY:

Date of last cervical smear: _____ Type of contraception: _____

Number of pregnancies: _____ Number of children: _____

Names and date of birth of children:

Date of Birth	Sex	Name	Type of Delivery ie ***caesarean/SVD***

PATIENT CONSENT FOR SMS AND E-MAIL COMMUNICATION

Home Tel. Number	Shared? (Y/N)	Mobile Tel. Number	Shared? (Y/N)

E-mail Address	Shared? (Y/N)	Other Tel. Number	Shared? (Y/N)

- I understand, agree and consent to Fairfield Medical Practice contacting me on the above detailed mobile phone number and e-mail address for appointment reminders, chronic disease management review reminders, flu vaccination clinic notifications, changes to service notifications, and health promotion information.
- I agree to advise the practice if my mobile number changes or if the phone is no longer in my possession, for example, if I lose my phone, sell it or pass it on to someone else for their use. I will notify the practice if this number becomes shared. Please note, we cannot send messages to shared mobile numbers or e-mail addresses.
- I acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions – the responsibility of attending appointments or cancelling them still rests with me.
- I also confirm that I have read and will comply with the requirements outlined in the patient information leaflet.
- I understand the above and

9NdP ☐ **(✓) Tick here to CONSENT to the SMS/E-mail communication service**

9NdQ ☐ **(✓) Tick here to DECLINE to the SMS/E-mail communication service**

Patient Agreement

Zero Tolerance Policy At Fairfield Medical Practice we promote an atmosphere of mutual respect between patients, relatives and staff members, as well as ensuring the safety of all parties. We aim to treat all patients and members of the public with dignity and respect and therefore request the same in return. We have a strict ZERO tolerance policy regarding any intimidating or aggressive behavior (this includes rudeness) towards ANY of the Medical Practice Staff, clinicians or other patients, either face-to-face or over the telephone.

Non-attendance at appointments We have a practice policy for dealing with persistent non-attendance of pre-booked appointments. We will write to any patient who does not attend 30 minutes of total appointment time within a 3-month period. Failure to attend appointments or cancel appointments on time beforehand, will prevent you pre-booking appointments and could ultimately affect your registration status with Fairfield Medical Practice.

Medication Policy

Many patients registering with Fairfield Medical Practice may already be prescribed medication from other practices. The doctors of the practice retain the right to decide not to continue prescribing such medication if it is not felt to be appropriate or of benefit to the patient. All cases will be assessed on an individual basis but proof of previous prescriptions from another doctor will generally be required from the outset. This is particularly true of medications which are recognised as potentially addictive (e.g. dihydrocodeine, diazepam, temazepam) and although they MAY be continued in certain circumstances, it might be in a reducing dose. The quantity given, the dose and frequency, again, will be at the discretion of the doctor, who has to accept responsibility for any prescription signed. Under **NO** circumstances will these scripts be re-issued if lost/stolen/mislaid.

Drug/Substance Misuse

We fully understand that some patients registering with Fairfield Medical Practice have a drug/ substance misuse problem. As a practice we are happy to deal with medical problems, which may arise, in the usual way and also to support patients in accessing help for their substance misuse issues. Patients however must refer themselves to Osprey House if they wish help in dealing with their drugs/ substance misuse.

The doctors in the practice will under NO circumstances prescribe reduction programme medication such as methadone to patients, unless directed by agreement with substance misuse services.

I confirm that I have completed the questions honestly and that I have read and agree to the above statements.

SIGNED:	**DATE:**