APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

NHS SCOTLAND

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 ask for form GMSTRF001)

Date of Birth* DD - MM - YYYY

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* DD - MM - YYYY

If previously resident in the UK, date of leaving* DD - MM - YYYY

Your most recent country of residence

If you have served in the British Armed Forces:

Enlistment date* DD - MM - YYYY

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* DD - MM - YYYY

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 CONSENT TO ORGAN 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.organdonation.nhs.uk.

Any of my organs and tissue ☐ Or my

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

Patient signature _____ Date DD - MM - YYYY

4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice 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 cards, 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 make sure that the information which identifies you as a person and your health information are separated or anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS National Services Scotland uses your personal information visit www.nhsnss.org. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality – it's your right', visit the Health Rights Information Scotland website at www.hris.org.uk or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

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, relevant information from this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

Patient/Patient's representative signature _____ Date DD - MM - YYYY

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)

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 DD - MM - YYYY

7. OFFICIAL USE ONLY

Input by _____

Checked by _____

Date DD - MM - YYYY

Practice Stamp

Queen's Crescent Surgery
New Patient Questionnaire

Personal Details

Full Name (incl. Title): _____

Address: _____

Telephone Number: (1) _____ (2) _____

Date of Birth: _____ Marital Status: _____

Occupation: _____

Ethnicity: _____

Next of Kin Name: _____ Relationship _____

Next of Kin Contact Details: _____

Health Details

Height: _____ Weight: _____ Blood Pressure (if known): _____

Allergies: _____

Current Medication: _____

Please tell us about current conditions, past illnesses, accidents, operations or other relevant hospital admissions: _____

Do you smoke: __ Yes / No __ If yes, how many per day? _____

If no, have you ever smoked: __ Yes / No __ When did you stop smoking? _____

What exercise do you undertake (if any): _____

How often: _____

Do you drink alcohol: __ Yes / No __ If yes, how many units per week? _____

To be answered by FEMALE patients only

When did you last have a cervical screening (smear) test: _____

Where was this taken: _____ Result (if known): _____

Continued overleaf…

Family History

Please list any illness that run in your family?

Diabetes	**Yes / No**	**Details:**
Stroke / TIA	**Yes / No**	**Details:**
Asthma	**Yes / No**	**Details:**
High Blood Pressure	**Yes / No**	**Details:**
Mental Health	**Yes / No**	**Details:**
Cancer	**Yes / No**	**Details:**

Other:

Other Relevant Information

Please use this space to write any other relevant information you would like your Doctor to know about:

Are you a carer:

FOR PRACTICE USE ONLY

Urinalysis:

Prescription: **Height:**

Weight:

Referral: **BP:**

FAST:

Dr Crighton / Ali / Other: **Date:**

FAST Screening


Bottle of wine (750 ml)

9.5 units


Glass of wine (250 ml)

3.1 units


Glass of wine (175 ml)

2.2 units


Medium strength lager (bottle)

1.7 units


Strong beer / lager / cider (1 pint)

3.6 units


Can of super-strength lager

4.0 units


Measurement of sprit (25 ml)

1.0 units

6 or more units on one occasion?

How often do you have:

8 or more units on one occasion?

Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)
⇩	⇩	⇩	⇩	⇩
-End- Low Risk			-End- High Risk	

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

Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

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

Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

In the last year, has a relative, friend, GP or health worker been concerned about your drinking or suggested that you cut down?

Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

FOR PRACTICE USE ONLY

FAST Score: _____ **Practitioner:** _____

ABI given: Yes / No **Date:** _____