WEST CALDER MEDICAL PRACTICE

Dr Steven Haigh, Dr Anne Campbell, Dr James Robertson, Dr Carol Simpson,
Dr Alastair McIntyre, Dr Judith McDermid
Practice Manager: Susan Millar

Dear

Thank you for applying to register with West Calder Medical Practice.

To confirm your identity, we require proof of address i.e. utility bill, passport or driving license etc. Photographic ID is not essential but it is helpful if you have it. If you do not hear from us within 14 days you can assume that your registration is confirmed.

You must complete the attached forms before you are seen.

Thank you for completing the form.

Yours sincerely

For Drs Haigh, Campbell, Robertson, Simpson, Campbell, McIntyre, McDermid

PLEASE NOTE:

All repeat prescriptions will initially be set up by our in-house Pharmacist. This is a safety and quality control procedure.

THE PHARMACIST WILL CONTACT YOU REGARDING SETTING UP REPEAT MEDICATIONS

Ref: wordconfig/receptletters/newregistrationletter&registrationpaperwork – SM - Dec 2020

PATIENT INFORMATION SHEET – Strictly Confidential

Designed for all age groups	**Date:**

Please complete appropriate sections as best you can

Full name:	Date of birth:
Maiden name:	Marital status:
Other surname:	Occupation:
Address:	
Post code:	Tel No:

HAVE YOU HAVE EVER BEEN REGISTERED WITH WEST CALDER MEDICAL PRACTICE AT ANY TIME IN THE PAST? YES □ NO □

Who lives at home with you?

.....

Name & Address of next of kin

.....

.....

Are you a Carer? Yes □ No □
(A Carer is someone who helps support a relative, friend or neighbour, who due to an illness, disability or age, cannot manage on their own)

If yes, please state name of person you are caring for

.....

Do you require and Interpreter? Yes □ No □

If yes, please state which language

.....

Name & Address of previous doctor:

Medical history – please list any major illnesses or admissions to hospital:

Allergies:

Date when you saw your doctor:

Date of last tetanus immunisation:

FOR CHILDREN *has your child had the following immunisations? Please give details:*

DTP	yes/no	Date:	**Polio**	yes/no	Date:
DT	yes/no	Date:	**MMR**	yes/no	Date
HIB	yes/no	Date:			

Which boosters were administered on entering school?: (***Please give details)***

BCG	yes/no	Date:	**Rubella**	yes/no	Date:

Tetanus booster on leaving school? yes/no Date:
Polio booster on leaving school?

FOR FEMALES
Number of pregnancies:
Number of miscarriages:
Have you had a cervical smear? yes/no Date:
Have you had breast screening? yes/no Date:

FAMILY HISTORY
Do you have any close relatives (mother, father, brother, sister or child) who, before the age of 60, has had |(please tick appropriate box (es)

a. Heart attack or angina □ Please state which relative (s)
.....

b. Stroke □ Please state which relative (s)
.....

SMOKING
Please tick the box which most closely represents your smoking habits:

a. Never smoked □
b. Stopped smoking (please give date):
c. Smoker – how many cigarettes per day?
d. Smoker: pipe/cigar/own roll (please specify) and state how much per day

Do you smoke your first cigarette within 30 minutes of waking up? □
Do you want to give up smoking? □
Are you ready to give up smoking? □
Would you like the doctor/nurse to help you give up smoking? □

ALCOHOL
How many units of alcohol do you drink per week?
(1 unit = 1 glass of wine, 1 measure of spirits or 0.5 pint of beer)

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.

Patient / Patient's representative signature | Date *

7. FOR OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp