Comrie Medical Centre
Strowan Road
Comrie
Perthshire
PH6 2LW
Tel:01764 670217
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Comrie Medical Centre

E-Mail: comrie.tayside@nhs.net

First of all, welcome to Comrie Medical Centre.

In this pack you will find:
NHS registration form
Comrie Medical Centre questionnaire
Child health immunisation form (**for under 5's only**)
Urine sample bottle (**for adults only**)
Email consent form (**please see note below)

Please tear off and keep this top letter for your information. Please fill out the rest of the paperwork as accurately as you can, ensuring that you sign the back of the NHS registration form as your application will not be activated until this is done. Please also ensure we have a contact telephone number for you in case of emergencies.

When you bring your registration form back to us please bring some form of identification. Suitable forms of ID include Passport, Drivers Licence, Birth Certificate, NHS Medical Card or Childhood Immunisations Book (red book).

Once we have received your registration it can take up to 6 weeks for your paper notes to arrive but you are more than welcome to make the following appointments:
New Patient Medical: This is really for adults but children with complex histories are welcome to a 20 minute appointment with a GP which covers everything including height, weight, medical conditions and repeat prescriptions. You do not have to have a new patient medical but is recommended if you have any ongoing treatment.
Normal Appointment: This is for any of our new patients and is a normal 10 minute appointment with a GP if you have something specific. Again, this is not compulsory; it is entirely your decision.

** If you give us permission to contact you via email then please sign the enclosed consent form and return with your registration paperwork.

Please see our website for more information:
www.comriemedicalcentre.co.uk

Dr. Catherine Carroll
M.B. Ch.B. M.R.C.G.P.
D.R.O.G. D.F.F.P

Dr. Ronnie Payne
M.B. Ch.B

Dr Philip Tipping
M.B. Ch.B. M.R.C.G.P.

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 - - 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 - - YYYY

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

Your most recent country of residence

If you have served in the British Armed Forces:

Enlistment date* DD - - YYYY

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* DD - - 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 - - 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 s heduling 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 - [ ] - 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 - [ ] - YYYY

7. OFFICIAL USE ONLY

Input by [ ]

Checked by [ ]

Date DD - [ ] - YYYY

Practice Stamp

WELCOME TO COMRIE MEDICAL CENTRE

TELEPHONE: 01764 670217

Welcome to The Comrie Medical Centre. All new patients over the age of 5 years are invited to make an appointment within the next 28 days to review their past medical history, drug treatment and present state of health. We should be grateful if you would complete the following simple questionnaire.

NB: Please note that you will be asked to provide proof of identity when registering with the practice.

Thank you.

NAME..... DATE.....

TITLE..... MARITAL STATUS.....

ADDRESS.....

.....

..... POSTCODE.....

DATE OF BIRTH..... TEL NO.....

OCCUPATION: .....

NAME AND ADDRESS OF PREVIOUS DOCTOR.....

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PRESENT MEDICAL PROBLEMS.....

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PRESENT MEDICATION WITH DOSE AND FREQUENCY.....

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PREVOUS MEDICAL CONDITIONS OR OPERATIONS (including pregnancies – if applicable) INCLUDING DATES.....

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ALLERGIES.....
(Are you allergic to any medicines?)

SPECIAL DIETS.....

PERSONAL /FAMILY HISTORY OF: (specify e.g. father, sister etc and age developed disease)

Asthma..... High Blood Pressure .....

Cancer..... ... Heart Disease (details if know).....

Diabetes..... Osteoporosis.....

Glaucoma.....

Other:

.....

.....

IMMUNISATIONS	DATES	
1st Triple, Polio & HIB		
2nd Triple, Polio & HIB		
3rd Triple, Polio & HIB		
Booster Dip/Tet/Polio		
MMR		
1st Meningitis		
2nd Meningitis		
3rd Meningitis		
BCG		
Tetanus		
Pneumovax		

FOR WOMEN	
HAVE YOU HAD A CERVICAL SMEAR?	YES/NO
DATE OF LAST SMEAR	

GENERAL SCREENING
Do you smoke? Yes / No How many? .....
Do you drink alcohol ? Yes / No How many units per week ..... (unit = 1/2 pint beer / 1 small glass of wine / 1 pub measure of spirits.
Height:
Weight:

ANY ADDITONAL COMMENTS: .....

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We should be grateful to have some information about your ethnic origin (We are asked to do this under the new GP contract)

Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background.

A. White

Scottish ☐

Other British ☐

Irish ☐

Any other White background (please specify) _____

B. **Mixed**

Any mixed background (please specify) _____

C. **Asian, Asian Scottish or Asian British**

Indian ☐

Pakistani ☐

Bangladeshi ☐

Chinese ☐

Any other Asian Background (please specify) _____

D. **Black, Black Scottish or Black British**

Caribbean ☐

African ☐

Any other Black background (please specify) _____

E. **Other Ethnic background**

Other Ethnic background (please specify) _____

F. **Other**

Prefer not to disclose ☐

FOR PRACTICE USE ONLY

URINALYSIS		DIET	
BP		EXERCISE	

COMMENTS:

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Name (Please Print).....

Date of Birth.....

Email Address.....

I do consent to Comrie Medical Centre contacting me via email

Signed.....