

## How to Register with Dollar Health Centre

### Rumbling Bridge Nursing Home

Please complete the form

*"Application to register permanently with a General Medical Practice".*

All boxes marked with a \* **MUST BE COMPLETED.**

#### Check List

- Have you completed and signed the *"Application to register permanently with a General Medical Practice" Form*
- Have you completed the *"New Patient Questionnaire Sheets"*
- Have you signed that you have received a copy of *"Your Information – Used and Protection"* on the *"New Patient Questionnaire Sheets"*

# 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\*  -  -  Address\*

Title\*

Surname\*

Forenames\*  Postcode\*

Previous Surname\*  Telephone #

email address #  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\*  Name and address of previous GP Practice in UK\*

Postcode\*   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\*  -  -  Service Number

Are you a Reservist?\*  Yes  No If yes, please provide your address before enlisting\*

Leaving date\*  -  -  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](http://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



Patient's Name .....

|                                     |       |       |       |
|-------------------------------------|-------|-------|-------|
| Please list all current medications |       |       |       |
| Name                                | Dose  | Name  | Dose  |
| -----                               | ----- | ----- | ----- |
| -----                               | ----- | ----- | ----- |
| -----                               | ----- | ----- | ----- |
| -----                               | ----- | ----- | ----- |
| -----                               | ----- | ----- | ----- |
| -----                               | ----- | ----- | ----- |
| Please list any allergies           |       |       |       |
| Drug                                |       |       |       |
| -----                               |       |       |       |
| -----                               |       |       |       |
| NonDrug                             |       |       |       |
| -----                               |       |       |       |
| -----                               |       |       |       |

**Current Health Status**

|   |          |           |
|---|----------|-----------|
| Patients Height   |          |           |
| Patients Weight   |          |           |
| Blood Pressure  | Systolic | Diastolic |
| Does the patient smoke?   | Yes/No   |           |
| If yes - how many per day?  |          |           |
| - would they like help to stop smoking?   | Yes/No   |           |
| Do the patient drink Alcohol?   | Yes/No   |           |
| If yes - how many units do they drink each week?<br>(1 unit = 1 glass wine/ ½ pint beer/ 1 standard measure of spirits) |          |           |

Patient's Name .....

Health Status Please circle the appropriate box

|  |                     |   |                                      |
|--|---------------------|---|--------------------------------------|
| Has the patient a Certificate of Incapacity?                         |                     | Yes   | No                                   |
| Does the patient need an assessment for a Certificate of Incapacity? |                     | Yes   | No                                   |
| Patients Mini Mental Health Score                                    |                     |   |                                      |
| Does the patient show any signs of dementia?                         |                     | Yes - please give details at the end of this document | No                                   |
| Does the patient have any cognitive difficulties?                    |                     | Yes - please give details at the end of this document | No                                   |
| Does the patient show any behavioural difficulties?                  |                     | Yes - please give details at the end of this document | No                                   |
| <b>Vision</b>  | Good                | Partial   | Contact Lens/Glasses                 |
| <b>Hearing</b>   | Normal              | Partial   | Has hearing aid                      |
| Right Ear  |                     |   | Registered Deaf                      |
| Left Ear   | Normal              | Partial   |                                      |
| <b>Communication</b>   | No Difficulties     | Minimal Speech difficulties                           | Needs assistance with communication  |
| <b>Mobility</b>  | Fully Mobile        | Walks with assistance/aids                            | Wheelchair                           |
| <b>Breathing</b>   | No Difficulties     | Difficulties on exertion                              | Difficulties with routine activities |
| <b>Sleep</b>   |                     |   |                                      |
| No of hours  | Continuous          | Disturbed   | Naps                                 |
| <b>Diet</b>  | Self Care for Meals | Assistance with Eating/Drinking                       | Carer provides Meals                 |
| Special Diet Yes/No  |                     |   | P.E. G Feeding                       |
| <b>Dressing and Personal Care</b>                                    | Self Care           | Personal Care Assistance req.                         | Dressing Assistance req.             |
|  |                     |   | Cannot care for self                 |
| <b>Bladder</b>   | No problems         | Slight Incontinence                                   | No bladder control                   |
|  |                     |   | Catheterised                         |
| <b>Bowels</b>  | No problems         | Slight Incontinence                                   | Occasional Accidents                 |
|  |                     |   | No bowel control                     |

Are there any other issues or information that the Doctors should be aware of:

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.....

.....

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.....

.....

.....

.....

Name of person completing this information ..... Date .....



Drs Houston, Baughan, Randfield and Meeten  
Health Centre  
Park Place  
Dollar

Nov 04

## “Your Information – Uses and Protection”

**We are registered with the Information Commissioner and our Data Controller is Dr Nell Houston.**

### What Information Do We Hold?

We hold data relevant to your medical care, and can include personal details, a record of your appointments and consultations, prescribed medications, test results, lifestyle and employment information.

### Who Has Access?

In addition to your doctors, the practice nurses, district nurses, health visitors and administration staff working at the health centre have access to your medical information.

Other attached medical professionals who have access to information about you are:

Visiting Colleagues offering specialist medical and support services, for example:

- Physiotherapist, Dietitian, Podiatrist
- Clinical Guidelines Co-ordinator
- Medical and Nursing Students

- but only in relation to the care they are providing.

### Sharing Information

Telephone calls made to NHS24 are recorded. A summary of the care you receive from NHS24 and the Out of Hours service is retained on a clinical system used by this organisation and a copy is in your medical record at this practice.

Everyone working in the NHS has a legal duty to keep information about you confidential. Great care is taken to ensure that confidentiality is maintained in respect of all information held about you.

If you are receiving care from other medical professionals or other organisations, we can provide information relevant to the care you are receiving.

### How Is the Information used?

In addition to using the information to provide you with proper and appropriate care and treatment, both the wider NHS and the Practice keep information relating to our activities.

Information is collated and used to plan health services (statistical anonymous data only) and to provide protection and monitoring of public health, investigate complaints, and to ensure quality of your care and treatments and to provide evidence of best practice.

The medical care and treatment you receive is audited, monitored and reviewed. Information specific to you is used to monitor your health, and used to audit the care we provide to our patients.

Although we may be using your information or asking you about treatment received, when the audit or report is completed all of the details which could identify you have been removed.

### Verification of Services

To ensure propriety and fiscal accountability a central NHS body called Practitioner Services can at times audit the practice.

To ensure that we are claiming correctly, Practitioner Services may contact patients to confirm that they have received the service claimed.

### Access to Health Records

The Data Protection Act (1998) gives you the right to access your health records both manual and computer records. Only in very exceptional circumstances can access be withheld.

Without your consent, no other person or organisation can access your records. With the exception of legal and statutory obligations, the only circumstances when information may be provided about you would be if the release of the information would be in the interest of the greater public good.

For example notification to DVLA of a medical condition which would preclude you from driving.

Applications for accessing your records must be made in writing and sent to the Practice Manager. There may be a charge for this service.

### Training

All doctors, nurses and staff receive annual training on confidentiality and data protection.

For more information please speak to the Practice Manager.