

Completing the Application to register permanently with a General Medical Practice.

It is really important that you complete this form and bring it with you to matriculation- this will help you avoid having to wait in a queue. You may not know all of the details to complete but try to fill in as much as possible. If you do have gaps don't worry as the staff will help you at matriculation.

Some of the information is self explanatory but from experience we know that students especially those coming from outside the UK can find the terminology difficult. So below is some information to help you.

1. **Surname-** Family Name
2. **Forename-** Given Name
3. **Middle Name-** other names between your given name and family name
4. **Title-** Mr, Miss, Ms
5. **Address-** is the address of where you will be living in St Andrews
6. **Mother's Maiden Name** – Your mothers surname on her birth/adoption certificate
7. **Previous Address in UK-** only complete this if you have previously lived in the UK
8. **Name and Address of previous registered GP practice in UK-** only complete this if you have lived previously in the UK; give the name and address of the GP Practice where you were registered before coming to St Andrews
9. **Community Health Index number-** Complete this if you are a resident in Scotland – the number that is on your yellow NHS card
10. **NHS Number-** only for UK residents. You will have been sent a card with this number on it
11. **National Insurance Number-** Complete this only if you have a NI Number - either a resident of the UK or have lived and worked in the UK previously
12. **Organ Donation-** for more information see <http://www.organdonation.nhs.uk/ukt/>

GPR

NHS IN SCOTLAND



APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

Please use BLOCK CAPITALS to complete the form and tick all relevant boxes

PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Eligibility to use the NHS services depends mainly on residence in the UK, and on other qualifying provisions set out in the Regulations. By completing this section fully, you will assist us in processing your application and locating any existing medical records promptly.

WILL YOU BE IN THE AREA FOR MORE THAN THREE MONTHS?*

YES NO

IS THIS YOUR FIRST REGISTRATION WITH A GP PRACTICE?*

YES NO

SURNAME *

[Grid for Surname]

TITLE #

[Grid for Title]

MALE *

FEMALE *

FORENAME *

[Grid for Forename]

MIDDLE NAME *

[Grid for Middle Name]

PREVIOUS SURNAME *

[Grid for Previous Surname]

DATE OF BIRTH *

[Grid for Date of Birth: D D M M Y Y Y Y]

ADDRESS *

[Grid for Address and Postcode]

TOWN & COUNTRY OF BIRTH *

[Grid for Town & Country of Birth]

MOTHER'S MAIDEN NAME *

[Grid for Mother's Maiden Name]

TELEPHONE NUMBER #

[Grid for Telephone Number]

EMAIL ADDRESS #

[Grid for Email Address]

PREVIOUS ADDRESS IN UK *

[Grid for Previous Address in UK and Postcode]

NAME AND ADDRESS OF PREVIOUS REGISTERED GP PRACTICE IN UK *

[Grid for Previous GP Practice Name, Address, and Postcode]

COMMUNITY HEALTH INDEX NUMBER

[Grid for CHI Number]

NHS NUMBER

[Grid for NHS Number]

NATIONAL INSURANCE NUMBER

[Grid for NI Number]

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.

ARE YOU RETURNING / HAVE YOU ARRIVED FROM ABROAD OR HM FORCES? *

YES NO

DATE OF DEPARTURE FROM UK

DDMMYY

DATE OF ENTRY/RETURN TO UK

DDMMYY

IF RETURNING FROM H M FORCES DATE ENLISTED

DDMMYY

SERVICE/PERSONNEL NO.

12 digit grid

COUNTER FRAUD 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 the Common Services Agency to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, I consent to the disclosure of relevant information from this form including to and by the NHS Business Services Authority, the Common Services Agency, UK Border Agency, Identity and Passport Service, the Department for Work & Pensions, HM Revenue and Customs, the General Register Office and Local Authorities.

PATIENT OR REPRESENTATIVE SIGNATURE

DATE DDMMYY

IF SIGNING AS A REPRESENTATIVE, PLEASE STATE:

YOUR NAME

28 digit grid

YOUR RELATIONSHIP TO THE PATIENT

28 digit grid

VOLUNTARY CONSENT TO ORGAN DONATION

I authorise the donation of (Please tick the boxes that apply)

A. any of my organs and tissue or my

B. kidneys heart liver small bowel eyes lungs pancreas tissue

for transplantation after my death

DDMMYY

PATIENT SIGNATURE

DATE

PRACTICE ACCEPTANCE AGREEMENT - for GP Practice use only

PRACTICE CODE

6 digit grid

GP NAME

20 digit grid

GP REFERENCE NUMBER

8 digit grid

IDENTIFICATION SEEN

MEDICAL CARD

BIRTH CERTIFICATE

PASSPORT

OTHER - SPECIFY _____

I accept this patient onto the practice list and declare that, to the best of my knowledge the information I have given on this form is correct and complete and I understand that if it is not, action may be taken against me. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be made to my Practice, which will be subject to Payment Verification. Where Common Services Agency is unable to obtain authentication, I acknowledge that the onus is on my Practice to provide documentary evidence to support this application.

GP SIGNATURE

DATE

DDMMYY

OFFICIAL USE ONLY

Input By:

Date:

Checked By:

Table with 3 columns: Input By, Date, Checked By

MEDICAL QUESTIONNAIRE

GP PRACTICES
ST ANDREWS COMMUNITY HOSPITAL

This questionnaire comes from the doctor with whom you will be registered while you are at University and is to help him/her. The information you give will be treated confidentially and will not be disclosed to the University or to any other party.

Please bring your medical card and/or completed Registration Form (GPR) with you to Matriculation where staff from the Health Centre will receive them.

Surname.....Forename.....Mr/Mrs/Miss/Ms/Other.....
Date of birth (dd.mm.yy) Sex: Female/Male Student ID No
Term time address: House No Room No Hall Name
Other: Postcode:
House Telephone No Mobile No
Expected end date of Course University Email address @st-andrews.ac.uk

PLEASE INFORM RECEPTION OF ANY CHANGE OF ADDRESS

ETHNICITY

White Scottish White British Other White Ethnic Group Please state:
Asian British Other Asian Please state:
Black British Black Other Please state:
Other Ethnic Group Please state: Ethnicity Refused/Not given

NAME & TELEPHONE NO OF NEXT OF KIN

PAST MEDICAL HISTORY

Please list all important illnesses, including hospital admissions and operations (continue overleaf if necessary)
.....

MEDICATION

Are you taking any regular medicines, including oral contraception, from your doctor or chemist? Please attach details with name of medication, dose and frequency
.....

FAMILY HISTORY

Have any of your relatives had:

	<u>Which relatives affected</u>	<u>Which relatives affected</u>
Asthma	Heart disease
Epilepsy	Diabetes
Stroke	High Blood Pressure.....

ALLERGIES

Do you have any allergies to medicines, if so, which ones?.....

PTO

DO YOU SMOKE? YES NO If yes please complete section below:
 CURRENT SMOKER 1/9 day 10/19 day 20/39 day
 EX SMOKER 1/9 day 10/19 day 20/39 day Year Stopped

DO YOU DRINK ALCOHOL? YES NO If yes please complete section below:
 Less than 1 unit/day 1/2 units/day 3/6 units/day 7/9 units/day More than 9 units/day

IMMUNISATION DATES

1st Diphtheria 1st Tetanus 1st Pertussis 1st Polio 1st Hib
 2nd Diphtheria 2nd Tetanus 2nd Pertussis 2nd Polio 2nd Hib
 3rd Diphtheria 3rd Tetanus 3rd Pertussis 3rd Polio 3rd Hib
 1st Meningitis C 2nd Meningitis C Booster Hib/Men C
 1st Pneumococcal 2nd Pneumococcal 3rd Pneumococcal
 1st Measles/Mumps/Rubella 2nd Measles/Mumps/Rubella
 Booster Diphtheria Booster Tetanus Booster Pertussis Booster Polio
 1st Hepatitis A 2nd Hepatitis A Booster Hepatitis A
 1st Hepatitis B 2nd Hepatitis B 3rd Hepatitis B Booster Hepatitis B
 1st Typhoid Booster Typhoid Yellow Fever
 Any Other (please state):

FEMALES ONLY: HAVE YOU EVER HAD A CERVICAL/PAP SMEAR? YES NO If yes, please state

Date smear taken What clinic carried out procedure
 Result of Smear - Negative/Normal Abnormal Date next smear due (if known)?.....

IS THERE ANY HEALTH ISSUE YOU WOULD LIKE US TO KNOW ABOUT?

Should you have any medical problem requiring ongoing input please make an appointment to discuss this.

Thank you.

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