WELCOME TO COVE BAY & KINCORTH MEDICAL CENTRE

In order to get you registered with us as quickly and efficiently as possible please read the following information.

Please complete all sections of the registration form for each family member registering at Cove or Kincorth.
NB – please ensure a current contact phone number is included.

In addition to the above information we will also require to see a passport/photographic ID for each member of the family registering and proof of address for everyone over the age of 16.

For patients from overseas – in addition, we will require to see any relevant visa. This is to ensure you are entitled to Health Care in the UK. Patients who do not qualify for Health Care under the NHS can still be seen at Cove and Kincorth surgery but fees will be applied for each consultation and prescription issued.

Once completed please return the form to the surgery with proof of your address – a utility bill or similar.

Once we have confirmed your details we will process your registration form. For those aged over 16, you will be contacted by a member of staff within 3 to 5 working days to offer you a new patient appointment with a Health Care Assistant. This is a 10 minute appointment to go over your medical history, medication etc. Please also bring a sample of urine in a clean container to the appointment.

If you have any questions regarding your registration, please contact the surgery on 0345 337 1170.

We thank you for registering with Cove Bay & Kincorth Medical Centre

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 complete a temporary resident form)

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 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 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 NHS Inform website at www.nhsinform.co.uk/rights/ 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

New Patient Registration Questionnaire

Welcome to Cove and Kincorth Health Centres. Please complete BOTH SIDES of this form and return wit your registration form. This will allow us have some information on hand, until your medical notes arrive fro the Health Board.

NAME:	DATE OF BIRTH:
ADDRESS:	OCCUPATION AND WORK ADDRESS

CONTACT TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER	DATE FORM COMPLETED

Do you have (or had) any of the following:	Please Tick **In your past medical history?** **DETAILS**	Please Tick **In your family history?** **DETAILS**
HEART CONDITIONS		
DIABETES		
ASTHMA		
CANCER		
HYPERTENSION		
STROKE		
OPERATIONS, TESTS, SERIOUS ILLNESSES		
ALLERGIES – please state		

Women Only:

When was your last cervical smear?_____

Can you give details of the result?_____

What is your current form of contraception?_____

Regular Medications:

Please provide details of all medications you take on a regular basis.

PTO

HEIGHT	WEIGHT
Do you want to be tested for a blood borne virus? Y/N	
DO YOU SMOKE (Have you ever smoked) Y/N IF YES: HOW MANY PER DAY_____ WHEN DID YOU START (& FINISH if appropriate) _____	**DO YOU CONSUME ALCOHOL** Y/N IF YES: HOW MANY UNITS PER WEEK_____
DO YOU HAVE ANY CHILDREN? IF SO, PLEASE STATE THEIR AGES	
CARERS: A) ARE YOU A CARER FOR SOMEONE? Y / N B) ARE YOU CARED FOR BY SOMEONE? Y / N IF YOU HAVE ANSWERED YES TO EITHER OF THESE QUESTIONS, PLEASE ASK FOR A CARERS PACK FROM RECEPTION.	

For all pre-school children out with Scotland it would be useful to have copies of immunisations provided to the Practice.

If you are on any medication which require regular blood test monitoring, please highlight this to us when you return your form so we can organise appointments for you. This includes drugs such as Warfarin, Lithium, Methotrexate, Azathioprine etc.

Branch Surgery
Kincorth Medical Centre
Provost Watt Drive
Kincorth, Aberdeen
AB12 5NA
Tel: 0345 337 1170
Fax: 01224 899182

Dr D. Fowler, Dr A.D. Jamieson,
Dr A.J. Henderson, Dr L.J. Mackenzie,
Dr C. Mitchell, Dr S. Kumar,
Dr C. Harris & Dr J. Chin

Consultations by Appointment Only

Main Surgery
Cove Bay Health Centre
Earns Heugh Road
Cove Bay, Aberdeen
AB12 3FL
Tel: 0345 337 1170
Fax: 01224 846857

Dear Patient

The Practice is gradually introducing a new system where patients can be sent a text reminder about their practice appointment a day before the appointment.

This is a gentle reminder about your appointment and gives you an opportunity to phone and cancel if it is no longer required. The system is being tried to help reduce our fail to attend rates and hence increase the availability of appointments for our patients.

A text message will be sent to the mobile number you have provided to the Practice. No confidential information or patient identifiable information will be sent in the text message.

Please sign the consent form below if you are willing for us to send you a text message to remind you of your forthcoming appointment.

Thank you,

The Partners of Cove Bay & Kincorth Medical Centre

I confirm that I have read and understood the information above and give the Practice permission to text me reminders about my forthcoming appointments I have booked at the Practice.

I understand it is my responsibility to inform the Practice if my mobile telephone number changes to allow them to update their records.

I understand that I can opt out of this anytime by writing to the Practice.

Name (Please Print) _____

Date of Birth _____

Mobile Telephone Number _____

Signature _____

Date _____

VISION ONLINE SERVICES - FOR THE ORDERING OF PRESCRIPTIONS

Vision Online Services (VOS) is a web-based application which has been developed to expand services available to patients from your GP Practice. VOS allows the patient to request services from their GP Practice online at a time that is convenient to them.

If you would like to register please fill out the attached Vision Online Patient Registration Form and return it to the practice **in person, along with a valid form of identification, for example photographic ID or your passport.**

Once you are registered for VOS, the practice will give you the information that will enable you to create a username and password. **Patients between the ages of 14-16 have the option to allow their parents / guardians to order their repeat prescriptions for them using their parents / guardians email address. Everyone over the age of 16 should use their own email address for this service.**

When you access the module a list of your repeat prescription requests will appear on the screen.

Simply select the item you require and submit your request. A message will be displayed indicating whether your request has been successful or not. Please note the messages will only be seen and dealt with by the administration staff.

IT IS IMPERATIVE THAT YOU ALLOW A MINIMUM OF 2 WORKING DAYS BEFORE COLLECTING YOUR PRESCRIPTION FROM THE PRACTICE.

IF YOU HAVE STATED THAT YOUR PRESCRIPTION IS TO GO TO A PHARMACY PLEASE ALLOW MORE TIME BEFORE COLLECTING YOUR MEDICATION.

COVE BAY & KINCORTH MEDICAL CENTRE
TEL: 0345 337 1170

Vision Online - Patient registration form

If you would like to register for this online service please complete the form below and return it to our practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password. Patients over the age of 16 should use their own email address for this service.

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Date of birth	/ / DD/MM/YYYY
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	/ / DD/MM/YYYY
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	DD/MM/YYYY

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	/ / DD/MM/YYYY