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 and Kincorth.

NB – Please ensure a current contact telephone 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 where possible.

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

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

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

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE

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

You have a choice about organ or tissue donation after your death. To find out more about why it is important that you take the time to make your donation decision and record it, go to www.organdonationscotland.org

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

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.

Authorised Practice signature

Date *

7. FOR OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp

New Patient Registration Questionnaire

Welcome to Cove and Kincorth Health Centres. Please complete BOTH SIDES of this form and return with your registration form. This will allow us have some information on hand, until your medical notes arrive from 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:	**In your past medical history?**	**In your family history?**
	Please Tick / DETAILS	Please Tick / 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

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.

ADDITIONAL INFORMATION

PATIENT NAME:_____

DATE OF BIRTH:_____

Sharing Information with Others

Sometimes it is useful to share your health information with other health professionals i.e. Hospitals, NHS24 or with GMEDS:

Do you give your consent for this? Please circle appropriate option

YES **NO**

Next of Kin

Name:_____

Address:_____

Relationship:_____ Contact Number:_____

Preferred Pharmacy

Please tell us your preferred pharmacy this enables us to send your prescription/ prescriptions automatically ready for your collection:

✓ Tick one option

Gardner Drive Pharmacy	
Abbotswell Pharmacy	
Holburn Pharmacy	
Ferryhill Pharmacy	
Whitelaws Pharmacy – Torry	
Albyn Pharmacy	
Rosemount Pharmacy	
Clear Pharmacy - Holburn	
Boots Garthdee Pharmacy	
Boots Bon Accord Pharmacy	
Boots Union Square Pharmacy	
Boots Mannofield Pharmacy	
Boots Mastrick Pharmacy	
Cove Pharmacy	

If you require an alternative Pharmacy please speak to a member of reception staff.

Signature _____ Date _____

Dear Patient

Since March 2019 the Practice offer a text message system to extend its functions beyond purely appointment reminders. This may include:

- Appointment reminders
- Rescheduling of booked appointments
- Invitations Chronic Disease clinics
- Information following new registration of yourself or a dependent with the practice
- Prescription notifications
- Updates following receipt of hospital correspondence
- Actions required following receipt of test results
- Our Duty team may also contact you regarding:
    - Fit notes
    - Prescriptions
    - Test results
    - Offering of emergency appointments
    - Signposts to other sources of help

This new system also allows for replies to be sent which will allow you to answer any questions asked or cancel an appointment.

A text message will be sent to the mobile number provided to the Practice. It is your responsibility to notify the Practice if your mobile number changes or becomes invalid.

Children aged over 12 must provide their own consent form.

Thank you

The Partners of Cove Bay & Kincorth Medical Centre.

I confirm that I have read and understand the information above and give the Practice permission to text me for any of the functions outlined above.

I understand that it is my responsibility to inform the Practice of any changes to my mobile number to allow the Practice to update their records.

I understand that I can opt out of this at any time by contacting the Practice.

Name (Please Print) _____

Date of Birth _____

Mobile Telephone Number _____

Signature _____

Date _____

COVE BAY & KINCORTH MEDICAL CENTRE
TEL: 0345 337 1170

Patient Services

Patient Services is a web-based application which has been developed to expand services available to patients from your GP Practice. Patient Services allows the patient to request services from their GP Practice online at a time that is convenient to them.
This service allows the patient to **request prescriptions.**

In order to ensure that you are ready for our changes, please fill out the attached Patient Services Registration Form and return it to the practice **in person, along with a valid form of Identification, for example photographic ID or your passport.**

Although you are registered with the practice already, and may currently use our website to order prescriptions, it is important for the practice to check everyone's identity for this new service so this is an extra security step we must take.

Once you are registered for Patient Services, 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.

PATIENT SERVICES - 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