

Overtoun Medical Practice

Rutherglen Health Centre, 130 Stonelaw Road, Rutherglen, G73 2PQ
Telephone 0141 531 6010
Email: Lan.clinicalovertounmedicalpractice60139@nhs.scot

Welcome to Overtoun Medical Practice

This registration pack may be taken away and completed.

Once you have returned the completed pack to us we will arrange a new patient nurse medical and after you have attended this appointment, you will be registered with the Practice.

Please read all of the enclosed information thoroughly and sign as appropriate.

If your new registration forms and your acceptable behaviour contract are not complete and signed, we will be unable to register you as a patient.

Enclosed in this pack are:

- Registrations Forms
- Acceptable Behaviour Contract
- Consent Form
- Practice Leaflet

OVERTOUN MEDICAL PRACTICE

Date:

Forename:

Date of Birth:

Surname:

Address:

Postcode:

.....

Telephone Number:

Mobile Number:

Marital Status:

Occupation:

Have you ever been registered with this Practice before: Yes/No

Previous GP name:

Address:

.....

Do you require an Interpreter: Yes/No

If Yes which Language:

Next of Kin:

Relationship:

Contact Number:

Have you suffered from any of the following diseases, please tick?

Asthma COPD Coronary Heart Disease Stroke/TIA

Epilepsy Hypertension Diabetes Mental Health Problems

Hypothyroid

Any other Medical Conditions:

Has an immediate member of your family suffered from any of the above? Please give details:

.....

Current Medication:

.....

Allergies:

Are you a Carer? Yes/No Who do you look after:

Do you have a Carer? Yes/No Who looks after you:

Females – Have you had a smear in the last 3 years? Yes/No Date:

Smoker: Yes/No Ex smoker, Date Stopped: Never Smoked

Alcohol Units: Weekly: Daily:

Height: Weight:

PLEASE BRING MEDICATION & SPECIMEN OF URINE ALONG TO YOUR NURSE APPOINTMENT.

ETHNIC MONITORING PATIENT INFORMATION LEAFLET

During your visit to your Doctors Surgery you will have the opportunity to make sure we have all your up-to-date information. This is important as addresses and telephone numbers can change frequently.

The NHS is also recording other important information such as language and also ethnic group.

The reason we are recording this information is:

- To help us communicate effectively and safely with all our patients.
- To help us understand health related to specific ethnic groups.
- To help us monitor our service.
- To help us when planning new services.
- To help us promote racial equality.

This information is confidential and is only used for health purposes. It is not used by any other organisations.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

Ethnic Group

- A. White
 - Scottish
 - Other British
 - Irish
 - Any other white background

- B. Mixed
 - Any mixed background specify

- C. Asian, Asian Scottish, Asian British
 - Indian
 - Pakistani
 - Bangladeshi
 - Chinese
 - Any other Asian Background

- D. Black, Black Scottish or Black British
 - Caribbean
 - African
 - Any other Black Background

- E. Any other Background Specify
- F. Other
 - Prefer not to say

Overtoun Medical Practice

130 Stonelaw Road, G73 2PQ

ACCEPTABLE BEHAVIOUR CONTRACT

We are committed to promoting access to our services and offering choice wherever possible in the services we provide and the way we deliver them. An acceptable behaviour contract is an individual written agreement between a patient and their GP Practice.

The contract is between (Patients name).....and Overtoun Medical Practice and is valid from the date of application to register.

The Conditions:

(Patients name)..... agrees to the following:

1. I agree to cancel any appointments I am unable to attend with as much notice as possible.
2. I agree to Overtoun Medical Practice DNA (did not attend) policy - if after I have missed 3 appointments without notifying the surgery I will be removed from the Practice list and will have to register with a different practice.
3. As a new patient I will not be registered with the Practice if I miss my new patient medical with the Practice Nurse or my first GP appointment, without prior cancellation.
4. I agree to adhere to Overtoun Medical Practice repeat prescription policy and agree to allow 2 working days before collecting my repeat prescription.
5. I agree to refrain from using abusive or offensive language, making threats of violence or aggressive behaviour and to treat all staff fairly and with respect; in person, on the phone, in writing or on social media.

Breach of this Contract:

If (Patients name) fails to adhere to the above conditions, they will be removed from the practice list. This contract serves as an initial warning in the event of breaches occurring.

When removal results from no. 5 above, any patients for whom this person is responsible, ie. child or cared for individual and who live at the same address, will also be removed to avoid any risk of further abuse to clinicians undertaking home visits for said child or cared-for individual.

- Overtoun Medical Practice will ensure you are dealt with quickly, fairly and in a courteous and helpful manner.
- Overtoun Medical Practice will ensure that staff take responsibility for resolving or dealing with your query or that they refer it to an appropriate colleague

Declaration:

I confirm that I understand the meaning of this contract and that the consequences of breaking the conditions of the contract.

Signed by..... (the patient)

Name:..... Date / /

Overtoun Medical Practice

Consent Form – Text Messaging and Prescription Collections

If you wish to opt in to the text messaging service please sign and date below. We will only message you appointment confirmations, appointment reminders and any other important information relating to the Practice. We will not text any marketing materials to you.

The text messaging service should not be relied upon and is an additional service that we provide.

“ I, the above named below, agree to being sent text messages from Overtoun Medical Practice”

Mobile telephone number

Signed by..... (the patient)

Name:..... Date / /

Please list any children under 18 you have who should be linked to the above mobile number:

.....

.....

.....

Prescription collection

Please list below anyone other than yourself who may collect your prescription on your behalf. We will not give your prescription to anyone other than those listed here. Children under 18 do not need to complete this.

“I, the patient, agree to the following named persons to collect my prescriptions on my behalf”

Name Relationship to you

Name Relationship to you

Name Relationship to you

Your name Signature Date.....

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 *

Email address #

Address *

Postcode *

Telephone #

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

If yes 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

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 | <input type="text"/> | Date * | <input type="text"/> |
| Representative's name (if applicable) | <input type="text"/> | | |
| Relationship to patient (if applicable) | <input type="text"/> | | |

6. FOR PRACTICE USE

| | | | |
|---------------------|----------------------|---------|----------------------|
| GP reference number | <input type="text"/> | GP name | <input type="text"/> |
| Practice code | <input type="text"/> | | |

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 <input type="checkbox"/> | Student ID card <input type="checkbox"/> | Driving licence <input type="checkbox"/> | Passport or HC2 cert <input type="checkbox"/> | Home Office app reg card <input type="checkbox"/> | Other / None <input type="text"/> |
|-------------------------------------|--|--|--|--|-----------------------------------|

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 | <input type="text"/> | Date * | <input type="text"/> |
|-------------------------------|----------------------|--------|----------------------|

7. FOR OFFICIAL USE ONLY

| | | |
|------------|----------------------|----------------------|
| Input by | <input type="text"/> | <input type="text"/> |
| Checked by | <input type="text"/> | |
| Date | <input type="text"/> | |