**WELCOME TO THE PRACTICE**

Drs M Johnston, Dr P Murray, Dr T Randall, Dr C Johnston, Dr N Harper, Dr L Fraser, Dr J Flinn, Dr C Gordon, Dr Eadie

**PLEASE COMPLETE THIS FORM FOR CHILDREN**

**5 YEARS AND UNDER**

We would like children you to have a new patient health check a 10 minute appointment with the doctor or nurse. This gives us an opportunity to find out about past and present health and helps us to get to know the Parents/guardian. **We encourage this offer, particularly if there is medication currently prescribed. Please book your appointment at Reception.**

**IF YOU REQUIRE ASSITANCE FILLING IN THIS FORM PLEASE ASK AT RECEPTION.**

Child’s full Name: ..............................................................................................................................................................

Date of Birth: ........................................................................ Gender: Male/Female: ......................................................

Child’s Parent(s)/Guardian: ..............................................................................................................................................

Previous Address & Postcode: .......................................................................................................................................

Previous GP: ....................................................................................................................................................................

Contact Telephone numbers

(M) ........................................................ (M):........................................................... (M).................................................

(H) ......................................................... Registered Disabled: YES / NO

Previous Address:…………………………………………………………………. Previous GP:……………………………..

Ethnicity: White Scottish □ White British □ Indian □ Chinese □ European □ Other Asian □ ………………….

Other please state:…………………………………………………………

Please give details of any operations, hospital admissions, major illness, diagnosis

……………………………………………………………………………………………………………. Date: ………………..

……………………………………………………………………………………………………………. Date: ………………..

……………………………………………………………………………………………………………. Date: ………………..

**CURRENT MEDICATIONS**

**NAME DOSE**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

PLEASE TURN OVER.........

**ALLERGIES**

Please give details of any allergies (foods, medications etc) .......................................................................................

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Immunisation: Are the childhood immunisations up to date? YES / NO

Please make the Red Book available to Reception so we can take details of the current immunisation status

IF THE CHILD IS ON ANY MEDICATION PLEASE MAKE AN APPOINTNMENT WITH A DOCTOR TO HAVE THE MEDICATION REVIEWED

**THANK YOU.**

**PLEASE PICK UP A COPY OF OUR PRACTICE BOOKLET OR VISIT** [**WWW.COWDENBEATHMEDICALPRACTICE.CO.UK**](http://WWW.COWDENBEATHMEDICALPRACTICE.CO.UK)

**THIS PROVIDES YOU WITH USEFUL INFORMATION ABOUT THE PRACTICE**

**IF YOU HAVE A MEDICAL CARD PLEASE HAND IT TO RECEPTION WITH THIS FORM**

**COWDENBEATH MEDICAL PRACTICE**

|  |  |
| --- | --- |
| 173 Stenhouse Street Cowdenbeath Fife  KY4 9DH  Tel. No. 01383 518500  Fax No. 01383 518509 | Dr. Marion Johnston  Dr. Natalie Harper  Dr. Paul Murray  Dr. Lucy Fraser  Dr. Colin Johnston  Dr. Tom Randall  Dr Jenny Flinn  Dr Carla Gordon |
| Practice Manager: Mrs Lisa Herd |  |

**CONSENT**

NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temporary Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applies)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE SECTION **1 OR 2** WHICH EVER SECTION APPLIES

**SIGN SECTION 3**

**SECTION 1**

**I\*consent / \*DO NOT consent** to the release of \*FULL or \*PART of my medical records by Cowdenbeath Medical Practice to:

..............................................................................................................................................................................

If Part medical records, please specify dates from …………………to…………………………………..........

**SECTION 2**

\*I consent to my Registered GP/GP Practice releasing medical information to Cowdenbeath Medical Practice for the purposes of health care provision during my temporary registration with Cowdenbeath Medical Practice

Key Information Summary/Emergency Care Summary :

\*I consent to Cowdenbeath Medical Practice accessing my emergency care summary, hospital electronic records for the purpose of health care provision etc.

Registered GP Name/Practice: ………………………………………………………………………..............

Tel: ………………………………………………………..

I understand that all written communications regarding my health care will still be sent to me at my address registered with Cowdenbeath Medical Practice

**SECTION 3**

Signed Consent:……………………………………………………………………………..

Print Name: ………………………………………………… Date: ………………….