**WELCOME TO THE PRACTICE**

Dr 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

Practice Manager Mrs Lisa Herd

**PLEASE COMPLETE THIS FORM FOR CHILDREN**

**5 YEARS AND UNDER**

**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 APPOINTMENT 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 JohnstonDr. Anne EadieDr. Paul MurrayDr. Lucy JonesDr. Colin JohnstonDr. Tom RandallDr Jenny FlinnDr Carla Gordon |
| Practice Manager: Mrs Lisa Herd |  |

**CONSENT**

NAME : ……………………………………………………………………….....................................

Permanent Address: ……………………………………………………………………….....................................

 ……………………………………………………………………….....................................

Temporary Address: ……………………………………………………………………….....................................

(If applies)

 ……………………………………………………………………….....................................

Date of Birth: ………………………… Tel No.:…………………………………………….....................................

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: ………………….

\*Delete as appropriate/if applicable