

# REGISTRATION APPLICATION FORM

## Catherine Street Medical Centre

<b>Name</b>	
<b>Address</b>	
<b>Eircode</b>	
<b>Date of Birth</b>	
<b>Phone No.</b>	
<b>E mail Address</b>	
<b>PPS</b>	
<b>Gender:</b>	
<b>Occupation:</b>	
<b>List of Current Meds</b>	
<b>Text Messaging</b> <small>Texting is not secure, your GP may text medical information. Pls protect your phone, read &amp; delete text messages. Advise GP if phone number changes</small>	<b>Do you consent to receiving lab results, details of screening services and appointment reminders via text messaging:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Have you or any member of your family been seen at this surgery before</b>	
<b>Nationality &amp; First Language</b>	
<b>Need interpreter:</b>	
<b>Currently hold a Medical Card</b>	
<b>Name and Address of previous GP</b>	
<b>Will you be applying for a Medical Card</b>	

<i>Do you suffer from any of the following :</i>		
	YES	NO
<b>ADHD</b>		
<b>Autism</b>		
<b>Heart Disease / High Blood Pressure</b>		
<b>Diabetes</b>		
<b>Psychiatric Illness</b>		
<b>Cancer</b>		
<b>Allergies</b>		
<b>Other illness / Please specify</b>		

<b>Why do you want to change GP?</b>	
<b>Why do you choose to join Catherine St. Medical Centre ?</b>	

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**SIGNING ON NEW PATIENTS:**

**We have a very limited capacity to accept new patients.**

**Frequently due to work pressure and to ensure a safe service we pause signing on any new applicants.**

**You are however welcome to fill in and submit the Registration application form and we will respond by email.**

**DATA PROTECTION:**

**We store your medical records electronically at the practice. This includes the information on this form, all medical notes taken at the practice, reports and correspondence from other health professionals. We sometimes need to share this information with other health professionals. We may be requested by insurance companies, banks, solicitors etc. for copies of some or all of your notes which we will provide on receipt of written consent from yourself. We store your PPSN number to facilitate us in the filling of forms for Social Insurance and other interactions with the government.**

**We have a Practice Privacy statement that we can supply on request.**

**Please sign below to consent to us processing and storing your personal data.**

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**Signature**

- **Like all GP surgeries we are very busy and doing our best we have a policy of dignity, kindness and empathy in the practice and expect this to be adhered to by everyone who enters the Medical Centre**
- **Please see [catherinestreetmedical.com](http://catherinestreetmedical.com). for frequently asked questions.**

**Office Use only**

<b>Form given out by:</b>	
<b>Form taken in by:</b>	
<b>Form reviewed by doctor:</b>	
<b>Scanned</b>	

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Catherine Street Medical Centre

*Catherine Street Medical Centre*

*18 Catherine Street, Waterford*  
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*Fax: 051-878265*

*Dr. Tony Lee Jnr., M.R.C.G.P. M.I.C.G.P. D.Obs. D.C.H. Dip. H.S.W. D.C.H. MC 06090*  
*Dr. Aine Hennigan D.Obs.,D.Psych.,D.Derm,M.I.C.G.P., L.F.O.M. MC 17496*  
*Dr. Sarah O'Brien M.B. , B.Ch., M.R.C.P.I., M.I.C.G.P., D.C.H. MC 22900*

Name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_

Re: *Transfer of Medical Records*

Dear Dr \_\_\_\_\_

*(This form will be used only if accepted as patient to the practice)*

The above named has decided to register with this practice. I would be grateful if you could send me a copy of their medical records. Signed patient consent in accordance with Data Protection Regulations has been provided below.

Notes may be transferred via Healthmail to  
[catherinestreetmedicalcentre.gp@healthmail.ie](mailto:catherinestreetmedicalcentre.gp@healthmail.ie)

Yours sincerely,

\_\_\_\_\_  
Doctor

I (Patient) \_\_\_\_\_ Date: \_\_\_\_\_

consent to the release of my medical records to Dr. \_\_\_\_\_