NHSScotland forms guidelines

Introduction

These guidelines define the parameters for designing forms.

They provide general guidance on how large the identity should appear and where it should be positioned, as well as demonstrating recommended layouts. Whether you're an administrative member of staff designing forms on PC or a professional designer using a Mac, you'll find all the core identity assets you need on this website.

For further information please contact nhsscotland@redpath.co.uk

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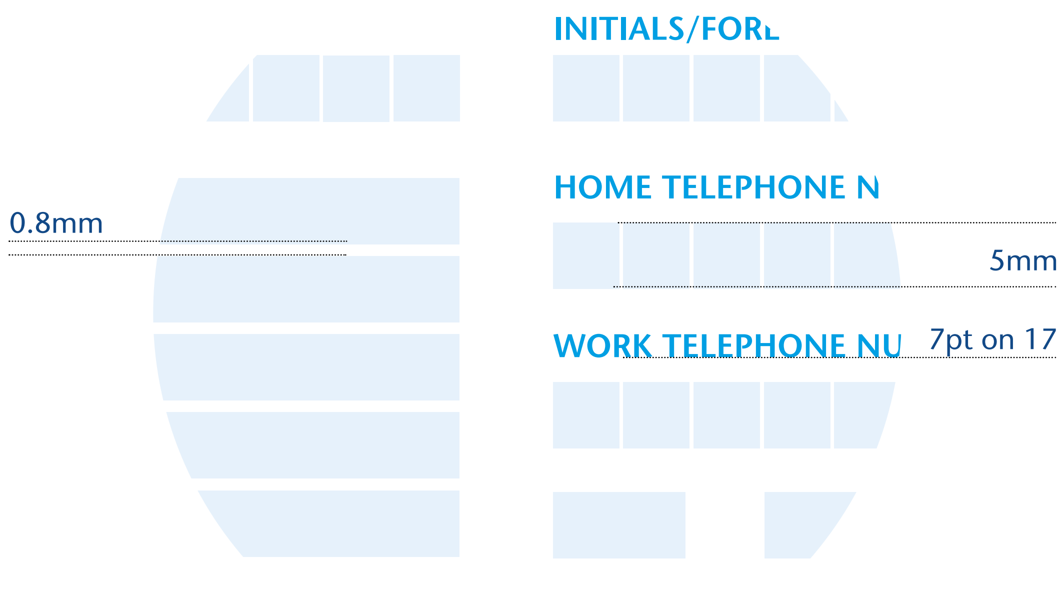
Design & layout

Clarity and ease of use are the guiding principles. Information should be gathered in as logical and straightforward a way as possible. Use plain English to prompt responses and provide defined areas for gathering the content. This helps to ensure that any handwritten content is as legible as possible.

When printing forms, use a 15% tint of NHSScotland Light Blue. Handwritten entries stand out well against this background. What's more, the tint disappears when photocopied, enabling the content to stand out clearly.

On computer generated forms, which are either printed or photocopied in black, only ever use a light tint of black for the information areas.

All of the forms shown on the following pages are for illustrative purposes only.



Detail shown at 175% of full size

NHS
Anyarea

Application for employment

Post:

Ref:

Place of employment:

Please return application by:

PLEASE COMPLETE THIS FORM AND THE ATTACHED EQUAL OPPORTUNITIES MONITORING FORM IN BLACK TYPE/INK

Personal details

SURNAME

INITIALS/FORENAMES

TITLE

HOME ADDRESS

HOME TELEPHONE NUMBER (OPTIONAL)

WORK TELEPHONE NUMBER

DRIVING

Qualifications

EXAMINATIONS/QUALIFICATIONS (OBTAINED AT SCHOOL, COLLEGE OR UNIVERSITY AND OCCUPATIONAL TRAINING eg SVQs)

Examination/Qualifications	Subject	Pass/Grade	Year

Employment History

NAME AND ADDRESS OF PRESENT OR MOST RECENT

JOB TITLE

DATE COMMENCED

ACTUAL SALARY

Outline of principal duties

Shown at 80% of full size

Confidential

EQUAL OPPORTUNITIES MONITORING

Any area NHS Trust is committed to a policy of equality of opportunity for both its staff and clients. The aim of the policy is to eliminate unlawful and/or unfair discrimination on grounds including gender, marital status, responsibility for dependents, disability (both mental and physical), sexual orientation, race, colour, ethnicity, nationality, religion, politics, beliefs, gender reassignment, Trade Union Membership or non-membership, HIV/AIDS status, social background, employment status and age; and to ensure that no person or group is disadvantaged unjustifiably.

To assist the Personnel Department in monitoring equal opportunities within the trust, we would be grateful if you could complete this form.

Name/Post

SURNAME

FORENAME

POST

POST REFERENCE NUMBER

Gender/ Marital Status

Please tick as appropriate

MALE

FEMALE

MARRIED

SINGLE

DIVORCED

SEPARATED

OTHER

DATE OF BIRTH

Nationality/Ethnic Origin

WHAT IS YOUR NATIONALITY?

IF APPOINTED IS A WORK PERMIT REQUIRED?
Please tick as appropriate

YES

NO

WHAT IS YOUR ETHNIC ORIGIN?
Please tick as appropriate

WHITE

BANGLADESHI

CHINESE

BLACK-AFRICAN

INDIAN

BLACK-CARIBBEAN

PAKISTANI

BLACK-OTHER

OTHER PLEASE SPECIFY

Disabilities

IF YOU CONSIDER YOURSELF TO BE DISABLED, PLEASE TICK

If called for interview, would you need any facilities/assistance e.g ramp access, large print material, a signer. If so,please give details:

Recruitment Advertising

WHERE DID YOU LEARN OF THIS VACANCY?
Please tick as appropriate

INTERNAL

VACANCY BULLETIN

NEWSPAPER*

EMPLOYMENT AGENCY

WORD OF MOUTH

JOB CENTRE

PROFESSIONAL JOURNAL*

OTHER*

*SPECIFY

Employment Service

ARE YOU AT PRESENT IN A NEW DEAL PROGRAMME – If so, please complete below

JOB CENTRE

NATIONAL INSURANCE NUMBER

Please return to: NHS Anyarea, Any Department, Anyarea Hospital, Any Street, Anytown xxxx xxx

Shown at 80% of full size

Employment History (last five years)

PLEASE BEGIN WITH THE MOST RECENT EMPLOYMENT AND EXACT DATES WHERE POSSIBLE

Name and Address of employer	Job Title and principal duties	dates from/to	Reason for leaving

Referees

Please give the name and addresses of two referees, at least one of whom should be your present or last employer or educational establishment where appropriate.

1. NAME

ADDRESS

POSITION

TELEPHONE NUMBER

MAY WE CONTACT THIS REFEREE PRIOR TO INTERVIEW?

YES NO

2. NAME

ADDRESS

POSITION

TELEPHONE NUMBER

MAY WE CONTACT THIS REFEREE PRIOR TO INTERVIEW?

YES NO

Criminal Convictions

Because of the nature of the work of the NHS this post is exempt from the Rehabilitation of Offenders Act 1974. Any convictions which you may have are not therefore considered to be spent and it is essential that you provide us with information about any convictions which you may have regardless of when these occurred. In the event of employment, any failure to disclose such convictions could result in disciplinary action by the Trust, including dismissal. Any information given will be completely confidential and considered only in relation to the particular post for which you are applying. The Trust will make further enquiries in such instances. A conviction is defined as anyone who is found guilty by a court of law, with or without penalty (e.g fine or imprisonment). Please note that an admonishment is a conviction without penalty and should be included on this form.

PLEASE GIVE DETAILS OF ANY OFFENCES

Declaration

SIGNATURE

DATE

Shown at 80% of full size

NHS
Anyarea

Application to register with a General Medical Practitioner

Please complete in BLOCK CAPITALS and tick relevant boxes

Patient details

SURNAME

FORENAME

PREVIOUS SURNAME

DATE OF BIRTH

MALE

FEMALE

I wish the child named above to be registered for Child Health Surveillance

RELATIONSHIP TO PATIENT

PATIENT / PATIENT REPRESENTATIVE SIGNATURE

ADDRESS

TOWN

COUNTY

POST CODE

I will be in the area for more than three months

DATE

Voluntary consent to organ donation

If you wish to register on the NHS Organ Donor Register as someone whose organs can be used for transplantation purposes after your death, please tick relevant box(es) below:

ANY ORGAN

KIDNEYS

LIVER

LUNGS

HEART

CORNEAS

PANCREAS

PATIENT'S SIGNATURE

DATE

Please help us to trace your medical records by providing the following information if known

NHS No. (not National Insurance No.)

PREVIOUS ADDRESS IN U.K.

TOWN

COUNTY

POST CODE

COMMUNITY HEALTH INDEX (CHI) NO.

NAME AND ADDRESS OF PREVIOUS DOCTOR IN U.K.

POST CODE

If returning from abroad

DATE OF DEPARTURE FROM U.K.

DATE OF RETURN TO U.K.

If returning from HM Forces

DATE ENLISTED

SERVICE / PERSONNEL NO.

If NONE of the above information is known then please complete the following:

TOWN OF BIRTH

COUNTY OF BIRTH

REG. DISTRICT OF BIRTH (see birth certificate)

MOTHER'S MAIDEN NAME

Doctor's agreement

ENTER 'D' IF SUPPLYING DRUGS

CHS ACCEPTANCE Y/N

ENTER DATE IF REGISTRATION EXAMINATION COMPLETED

DOCTOR'S SIGNATURE

DATE

MILEAGE CLAIM

ROAD

WATER

FOOTPATH

CHS REF NO. OF GP PROVIDING SERVICE IF DIFFERENT FROM BELOW

DOCTOR'S NAME

DATE

Shown at 80% of full size

The General Hospital Anyarea

NHS Anyarea

Immediate discharge letter

IN CONFIDENCE

WHITE COPY – GIVE TO PATIENT FOR DELIVERY TO GP
PINK COPY – CASENOTE
BLUE COPY – PHARMACY

General Practitioner Details

NAME

ADDRESS

Patient's Details

Please complete in BLOCK CAPITALS

SURNAME

FORENAME

DATE OF BIRTH

UNIT NO

ADDRESS

HOSPITAL

WARD/DEPT

CONSULTANT

Discharge

Your patient attended / was admitted* on and was discharged on home / to*

PRINCIPAL DIAGNOSIS / OPERATION

TREATMENT / COMMENTS

DRUG SENSITIVITY

DIAGNOSIS DISCUSSED

GP

PATIENT

NEXT OF KIN

Follow–up

HOSPITAL

FURTHER REVIEW

PLACE

DATE

TIME

FURTHER INVESTIGATIONS PENDING

GP

FURTHER TREATEMENT ADVISED

TO ATTEND GP SURGERY

UNABLE TO ATTEND SURGERY

FOLLOW–UP NOT REQUIRED

DOMICILIARY SUPPORT

RECOMMENDED

ARRANGED BY HOSPITAL

Medication on discharge

a 7 day supply will be dispensed unless otherwise requested

	MEDICINE	FORM	DOSE	ADMINISTRATION TMES					ADDITIONAL INSTRUCTIONS	QUANT	PHARMACY COMMENTS	PHARM SIG
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												

PRESCRIBED BY

DATE

DISPENSED BY

DATE

PHARMACIST CHECK

DATE

FINAL CHECK BY

DATE

Shown at 80% of full size

Notes

1. Please inform the Appointments Office if you are unable to keep our appointment
2. In any communication with the Hospital, please quote your Unit No. or enclose this card
3. If you change your address and/or your doctor, please notify the Appointments Office by letter or telephone
4. Do not arrive too early for your appointment
5. Please keep this card and bring it with you when you attend the Hospital
6. If you are requested to attend again, make your next appointment at the office before leaving
7. SUGGESTIONS / COMPLAINTS. Should you wish to make any suggestion or complaints about your visit to the hospital, please consult the notices displayed in the Out-Patient Dept. as to the action to be taken

Anyarea

Out-Patient appointment card

Any Hospital, Any town Tel 0123 456 7890 / 0123 456 7890

UNIT

NAME (MR / MRS / MISS)

ADDRESS

Important: Please read all documentation enclosed.
Please bring any medication with you

An appointment has been made for you to be seen at

CLINIC

DATE

TIME A.M. / P.M.

Your next appointment

DAYS/WEEKS	A OR C	CLINIC	DATE	TIME
				A.M. P.M.
				A.M. P.M.
				A.M. P.M.
				A.M. P.M.
				A.M. P.M.
				A.M. P.M.
				A.M. P.M.

Shown at 80% of full size

The General Hospital Anyarea

NHS Anyarea

Admission Form

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS AND BRING IT WITH YOU WHEN YOU COME FOR ADMISSION

Patient's Details Please complete in BLOCK CAPITALS

SURNAME Mr/Mrs/Ms/Miss/Dr/Rev*

FORENAME

DATE OF BIRTH FEMALE MALE RELIGION

SINGLE / MARRIED / SEP. / WIDOWED / DIVORCED*

ADDRESS

NATIONALITY

TELEPHONE NUMBER

DAY

NIGHT

OCCUPATION

SELF

HUSBAND / PARENTS*

MAIDEN NAME

If you are a visitor from Overseas

HAVE YOU BEEN RESIDENT IN THE UK FOR OVER 12 MONTHS? YES / NO*

DO YOU INTEND TO LIVE PERMANENTLY IN THE UK? YES / NO*

Government Pensions/Allowances

RETIREMENT

INCOME SUPPORT

ATTENDANCE ALLOWANCE

OTHER TYPE

IF YOU DO NOT HOLD THE BOOK PLEASE STATE WHO DOES

NAME /ADDRESS

General Practitioner

NAME / ADDRESS

Next of Kin

NAME / ADDRESS

RELATIONSHIP

TELEPHONE NUMBER

DAY

NIGHT

Emergency Contact IF DIFFERENT FROM ABOVE

NAME / ADDRESS

RELATIONSHIP

TELEPHONE NUMBER

DAY

NIGHT

Information for Chaplain

MAY WE INCLUDE YOUR NAME ON YOUR OWN MINISTER / PRIEST'S LIST? YES / NO*

IF YES, PLEASE GIVE HIS NAME AND ADDRESS

THANK YOU FOR COMPLETING THIS DOCUMENT. PLEASE HAND IT TO THE RECEPTIONIST AT CENTRAL ADMISSIONS OR IF ASKED TO GO DIRECT TO THE WARD, TO THE NURSE IN CHARGE

For official use

C.R.N.

DATE OF ADMISSION

WARD

SPECIALTY

ADMISSION FROM (see back of form)

TYPE OF ADMISSION (see back of the form)

DAY CASE / PRIVATE*

DATE PLACED ON W.L. / ARRANGED*

CONSULTANT

ADMISSION REASON

OTHER INFORMATION

Diagnosis FOR DAY CASES ONLY

MAIN CONDITION

OTHER CONDITIONS

1

2

OPERATIONS / PROCEDURES

1

2

Shown at 80% of full size

Form GP10

SCOTLAND

NAME

ADDRESS

POSTCODE

Age if under 12 years month

NO. of days treatment CHI number

DISPENSING ENDORSEMENT

PACK SIZE numbers only

PACK SIZE numbers only

PACK SIZE numbers only

SIGNATURE OF DOCTOR DATE

CRASH NUMBER POSITION

PLEASE READ NOTES OVERLEAF AND COMPLETE RELEVANT PARTS **BEFORE** GOING TO A PHARMACY

GP10 Important notes for patients

- Prescriptions marked URGENT by the doctor may be obtained outside normal hours
- If you think you might be entitled to a refund of the money you have paid, you must get an NHS receipt (EC57) when you pay. You cannot get one later.
- If you need a lot of medication you may want to buy a prepayment certificate.
- To find out more about prescription charges, get leaflet HC11 "Are you entitled to help with health costs?" from your pharmacist.

Part A

I AM THE PATIENT THE PATIENT'S REPRESENTATIVE (X in box)

Part B

I HAVE PAID THE SUM OF £ . FOR THE ITEMS OVERLEAF

or Part C

THE PATIENT DOES NOT HAVE TO PAY BECAUSE HE/SHE (X in appropriate box)

- IS EXEMPT ON AGE GROUNDS:

A under 16 years of age B 16, 17, 18 and in full time education

C 60 years of age or over

- HOLDS AN EXEMPTION CERTIFICATE:

D maternity or medical exemption (EC92) E prepayment certificate (EC96)

F War/MoD pensioner exemption certificate – and the items overleaf are for the pensionable disability

- RECEIVES OR IS THE PARTNER OF SOMEONE RECEIVING:

G Income Support H Family Credit

I Disability Working Allowance J Income-based Jobseeker's Allowance

K a current HC2 NHS charges certificate for full help

Name of person getting benefits date of birth

L The item prescribed is a free-of-charge contraceptive

YOU MAY BE ASKED TO PRODUCE EVIDENCE OF EXEMPTION

NHS USE ONLY EVIDENCE NOT PRODUCED

Part D

MUST BE COMPLETED BY / ON BEHALF OF THE PATIENT

I declare that the information is true and complete date

SIGNED

NAME in capitals

ADDRESS if different from overleaf

WARNING FALSE INFORMATION MAY LEAD TO PROSECUTION

Shown at 70% of full size

Security pattern

Where there is a need to ensure that a form cannot be copied easily by a third party, the following pattern should be incorporated into the document as a background.

The pattern, which is created from an outline version of the caring symbol, is available as a mac eps in the digital assets section.