**Dingwall Medical Group**

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T 01349 863034

**The Health Centre**

**Ferry Road**

**Dingwall**

**IV15 9QS**

**TEMPORARY RESIDENT FORM**

|  |  |
| --- | --- |
| **Date** |  |
| **Full Name** |  |
| **Date of Birth** |  |
| **Temporary Address** |  |
|  |
|  |
| **Mobile Number** |  |
| **Home Address** |  |
|  |
|  |
| **Home Phone Number** |  |
| **Registered GP**  |  |
| **Practice Name & Address** |  |
| **Patient Signature****or****Representative Signature** |  |
| **Name & Relationship to Patient** |  |
| For Practice Use Only – Circle as appropriate:Temporary Resident? YES / NO  *LESS than 16 days* **or** *16 days to 3 months?*Emergency Treatment? YES / NOImmediate Necessary Treatment? YES / NOAged 5 years or less? – copied to HV YES / NO |