PATIENT PARTNER REGISTRATION FORM

Name:			
Address			
Date of Birth		Telephone:	
Email:		Mobile:	

How would you like to be contacted (please circle)? **Post /** **Telephone** **Email**

Do you drive (please circle)? **Yes** **No**

Please indicate what type of condition you have symptoms of:-
(you may indicate more than one)

Cardiovascular: (heart, circulation, stroke)	
Respirator: (breathing problems)	
Gastrointestinal: (stomach, bowels, liver etc.)	
Muscle and Joint Conditions:	
Diabetes:	
Renal:	
Other:	

Please supply any further medical information you feel is relevant (please note you may leave this section blank if you wish).

To help us recruit more Patient Partners, please tell us how you first heard about our programme:

Please let us know about any mobility problems: _____

_____

By signing this form I agree for my details to be held securely with St Andrews University Medical School and to be contacted regarding the above teaching program. We will not pass these details on to any third party.

Signature _____ Date _____

On occasion, we ask Patient Partners if they are willing to have a brief physical exam. **This is entirely optional.**

By signing this form, I agree to have a physical examination of the following area of the body. I understand that this is not a binding agreement, and that I can change my mind at any time.

head and neck		limbs	
Abdomen		any	
Chest			

Please note: an abdominal exam will go no lower than the pants line and women will not be asked to remove their bra. No one other than the doctor/nurse leading the session and the students will be present in the completely private area. Please be assured that our students are required to adhere to strict standards of confidentiality.

We are most grateful to all our Volunteer Patients for their willingness to give their time to help us improve medical training.

Please return this form to: Patient Partner Coordinator, School of Medicine, University of St Andrews, North Haugh, St Andrews Fife KY16 9TF