

PATIENT FORM FOR NOTIFYING THE PRACTICE OF A CHANGE OF ADDRESS

Please complete a form for EACH patient who is changing their address:

FULL NAME:

OLD ADDRESS:

.....

.....

POST CODE:

TELEPHONE NUMBER:

MOBILE PHONE NUMBER:

NEW ADDRESS:

.....

.....

POST CODE:

TELEPHONE NUMBER:

MOBILE PHONE NUMBER:

Receptionist to complete with the patient:

The new address is within our practice boundary and the practice can continue to provide the patient's care YES NO*

*If the receptionist has indicated NO – ensure that the patient has been verbally informed of the need to change their GP to one providing services at their new address.

*Receptionist to initial that confirmation of verbal instruction provided to patient to register with GP practice at their new address:

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Receptionist to initial that workflow note sent to designated Receptionist advising that patient has been verbally instructed to change their GP to one providing services at their new address:

Receptionist to initial that Patient's new address has been amended on EMIS:

Patient signature confirming above information is correct:

Full name of Patient

Date of signing

Receptionist initials to confirm that above information is correct:

Date of initialling