**CRADLEY SURGERY**

**NOTIFICATION OF CHANGE OF NAME AND/OR ADDRESS**

(*a separate form must be completed by each family member)*

**Identification Must be presented to Verify Patient**

|  |
| --- |
| Method of verification  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 |

|  |  |
| --- | --- |
| (Previous) Full Name and Date of Birth | New Name (if applicable) |
| Previous Address | New Address |
| **Please keep us up to date with next of kin and your contact details** | |
| Your Telephone number  Your mobile number  Your email address | Next of Kin  Relationship to you  Address and Contact no of NOK |
| Patient Signature | Signed on behalf of  Name (Print)  Relationship to patient  Signature |

Your email address may be used for communication between the surgery and yourself concerning information and events at the practice. If you choose not to be contacted in this way please inform the surgery.

|  |  |  |
| --- | --- | --- |
| *For office use only*  *(****if patient has moved back IN to our area do* Do OOA alerts need to be removed from record?**  **And code 912N? and Dispensing Status change? Reprint OOA list for reception If so.** | | Staff initials and date |
| Received by  Date Stamp | Record changed on EMIS  Lloyd George or A4 notes changed  Scanned to patient record |  |

(*a separate form must be completed by each family member)*

|  |  |
| --- | --- |
| Patient has moved outside of our practice boundary: | |
| 1. Form to Dr. Dye for her decision on whether patient may remain on our list (subject to accepting the terms of our OOA Policy) | Yes  No  If Yes proceed to step 2, If no please state reason here |
| 1. Please pass this form to secretaries to follow the Out of Area Patient procedure. |  |

W:\General Admin\RECEPTION FORMS\Change of name and address forms.rtf

For Procedure please follow SOP A4