

FAMILY DOCTOR REGISTRATION SERVICES
(NOT FOR REGISTERING PATIENTS FROM OUTSIDE UK)

HS 200



Patient details

Please complete in BLOCK CAPITAL AND TICK ✓ as appropriate

Mr Mrs Miss Ms

Surname

Date of Birth

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First Names

Previous Surname/s

H+C No.
(If known)

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Male Female

Town and country
of birth

Current address

Postcode

Telephone No.

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

.....

Address of previous doctor

Did you get a Medical Card showing your previous address? Yes or No

If you are returning from the armed forces

Address before enlisting

Service or
Personnel number

Enlistment Date
Discharge Date

I understand that the Business Services Organisation may be legally obliged to disclose the data included on this form to relevant statutory authorities for the purposes of prevention, detection and investigation of crime. Furthermore, I understand the organisation may also share this data for health research purposes and with organisations responsible for delivering health and care services in order to facilitate the management of those services.

Information about data security and confidentiality matters can be obtained from the Organisations Data Protection Co-ordinator: 2 Franklin Street, Belfast, BT2 8DQ, telephone 028 9053 5549.

Signature of patient Signature on behalf of patient.....
Date

Doctor's Name
Authorised Signature

GP Code
Date

NHS Organ Donor Registration

Data Protection Assurance: Completion of this section is for the sole purpose of recording your wishes on the NHS Organ Donor Register. All data processed by UK Transplant is in accordance with the Data Protection Act, 1998. Your details will only be used for administration purposes by UK Transplant staff or agents and will not be released to any third party without your written consent.

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick

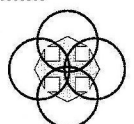
Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature of patient for Organ Donation



INVESTOR IN PEOPLE

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Family Practitioner Services