

If completing by hand please use BLOCK CAPITALS and tick boxes ✓ as appropriate.

Patients Details		<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Miss	Surname/Family Name
Date of Birth (DD/MM/YYYY)			First Names
NHS no.			
<input type="checkbox"/> Male <input type="checkbox"/> Female		Town and Country of birth	
Address (residence whilst at this University)		Telephone:	
Postcode:		Mobile:	
		Email:	

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

Your previous address in UK	Name of your previous doctor at that address:
	Address of previous doctor
Postcode:	

<p>If you are from abroad Your first UK address where registered with a GP</p>	<p>If you are returning from the Armed Forces Address before enlisting</p>
<p>If previously resident in the UK, date of leaving</p>	<p>Service/Personnel No.:</p>
<p>Date you first came to the UK:</p>	<p>Enlistment date:</p>

<p>If you are registering a child under 5 <input type="checkbox"/> I wish the child to be registered with the doctor named overleaf for Child Health Surveillance</p>	<p>If you need your doctor to dispense medicines and appliances* <input type="checkbox"/> I live more than 1 mile in a straight line from the nearest chemist <input type="checkbox"/> I would have serious difficulty in getting them from a chemist. <i>*not all doctors are authorised to dispense medicines</i></p>
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Signature of Patient	Signature of behalf of patient	Date
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**Please complete, PRINT and sign and send to The Health Centre, University of Warwick, Coventry CV4 7AL
Please see overleaf for ORGAN DONATION**

To be completed by the doctor		Doctors Name:	HA code:
<input type="checkbox"/> I have accepted this patient for general medical services <input type="checkbox"/> for the provision of contraceptive services only <input type="checkbox"/> I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice:-			
Doctor's name (if different from above)		HA code	
<input type="checkbox"/> I am on the HA CHS list and will provide Child Health Surveillance to this patient, or <input type="checkbox"/> I have accepted this patient on behalf of the doctor named below who is a member of this practice, and is on the HA CHS list and will provide Child Health Surveillance			
Doctor's name (if different from above)		HA code	
<input type="checkbox"/> I will dispense medicines/appliances to this patient subject to the Health Authority's approval			
<input type="checkbox"/> I am claiming rural practice payment for this patient. Distance in miles between my patient's home address and my main surgery is			
I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.			
Authorised signature		Practice Stamp	
Name	Date		

NHS Organ Donor Registration

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

<input type="checkbox"/> Kidneys	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Corneas	<input type="checkbox"/> Lungs	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Any part of my body
<i>Signature confirming consent to organ donation</i>		<i>Print your name</i>		<i>Date</i>		

If you would like to join the NHS Organ Donor Register, please complete this form, PRINT and sign it and send it to
The Health Centre, University of Warwick, Coventry CV4 7AL



For more information, ask for the leaflet on joining the NHS Organ Donor Register or visit the website at <http://www.uktransplant.org.uk>