ASSIGNMENT FORM

PATIENT ASSIGNMENT TO A NHS GENERAL MEDICAL PRACTICE

- Please use **BLOCK CAPITALS** to complete the form and tick all relevant boxes.
- Failure to complete this form fully may delay locating any medical records promptly.
- All assignments are issued to practices on a strictly rotational basis.
- Eligibility to use the NHS services depends mainly on residence in the UK, and on other qualifying provisions set out in the Regulations.
- The patient, or their representative, **must** sign the declaration overleaf.

PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

WILL YOU BE IN THE AREA FOR MORE THAN THREE MONTHS? * YES ☐ NO ☐

IS THIS YOUR FIRST REGISTRATION WITH A GP PRACTICE IN THE UK? * YES ☐ NO ☐

SURNAME *

TITLE (Not held on CHI)

MALE * ☐ FEMALE * ☐

FORENAME *

MIDDLE NAME *

PREVIOUS SURNAME *

DATE OF BIRTH *

CURRENT ADDRESS *

POSTCODE *

E-MAIL ADDRESS (Not held on CHI)

CONTACT TELEPHONE NUMBER (Not held on CHI)

TOWN OF BIRTH *

MOTHER'S MAIDEN NAME *

COUNTRY OF BIRTH *

PREVIOUS ADDRESS IN THE UK *

POSTCODE *

NAME AND ADDRESS OF PREVIOUS REGISTERED GP PRACTICE IN THE UK *

POSTCODE *

COMMUNITY HEALTH INDEX NUMBER

NATIONAL HEALTH SERVICE NUMBER

IF YOU ARE FROM ABROAD:

DATE YOU FIRST CAME TO LIVE IN THE UK? | IF PREVIOUSLY RESIDENT IN THE UK, DATE OF LEAVING.

YOUR MOST RECENT COUNTRY OF RESIDENCE

IF YOU HAVE SERVED IN THE BRITISH ARMED FORCES:

SERVICE / PERSONNEL NUMBER

ARE YOU A RESERVIST IN ANY OF THE BRITISH ARMED FORCES? YES ☐ NO ☐

DATE OF YOUR ENLISTMENT | DATE OF YOUR LEAVING

IS THIS YOUR FIRST REGISTRATION WITH A GP SINCE LEAVING THE ARMED FORCES? YES ☐ NO ☐

VOLUNTARY CONSENT TO ORGAN DONATION

I authorise the donation of (Please tick the boxes that apply)

any of my organs and tissue ☐ or my

Kidneys ☐ Eyes ☐ Heart ☐ Lungs ☐ Liver ☐ Pancreas ☐ Small bowel ☐ Tissue ☐

for transplantation after my death.

PATIENT SIGNATURE _____ DATE

HOW WE USE YOUR INFORMATION

THE INFORMATION YOU HAVE PROVIDED WILL BE USED BY THE GP PRACTICE TO CARRY OUT ITS VARIOUS FUNCTIONS AND SERVICES INCLUDING SCHEDULING APPOINTMENTS, ORDERING TESTS, HOSPITAL REFERRALS AND SENDING CORRESPONDENCE.

YOUR INFORMATION, INCLUDING YOUR NAME, GENDER, DATE OF BIRTH AND ADDRESS, WILL BE PASSED TO NHS NATIONAL SERVICES SCOTLAND WHERE IT WILL BE HELD ON THE COMMUNITY HEALTH INDEX (CHI). THIS INFORMATION IS USED TO REGISTER YOU WITH A GP PRACTICE, TRANSFER YOUR MEDICAL RECORDS BETWEEN GP PRACTICES IN THE UK, MAKE PAYMENTS TO GP PRACTICES FOR MEDICAL SERVICES PROVIDED, AND TO PROCESS AND ISSUE MEDICAL CARDS, MEDICAL EXEMPTION CERTIFICATES AND ENTITLEMENT CARDS.

NHS NATIONAL SERVICES SCOTLAND SHARES INFORMATION ABOUT YOU WITHIN NHSSCOTLAND TO ASSIST IN THE PROVISION AND IMPROVEMENT OF NHS SERVICES AND THE HEALTH OF THE PUBLIC. WHEN WE DO THIS, WE MAKE SURE THAT THE INFORMATION WHICH COULD IDENTIFY YOU AS A PERSON AND YOUR HEALTH INFORMATION ARE SEPARATED OR ANONYMISED. HEALTH CONDITION AND TREATMENT INFORMATION WHICH COULD IDENTIFY YOU WILL NOT BE USED FOR RESEARCH PURPOSES BY THE NHS UNLESS YOU HAVE CONSENTED TO THIS.

FOR MORE INFORMATION ON HOW NHS NATIONAL SERVICES SCOTLAND USES YOUR PERSONAL INFORMATION VISIT OUR WEBSITE AT WWW.NHSNSS.ORG IF YOU HAVE ANY QUERIES OR CONCERNS ABOUT HOW YOUR PERSONAL INFORMATION IS USED BY THE NHS PLEASE ASK FOR THE LEAFLET 'CONFIDENTIALITY – IT'S YOUR RIGHT', VISIT THE HEALTH RIGHTS INFORMATION SCOTLAND WEBSITE AT WWW.HRIS.ORG.UK OR ASK YOUR GP SURGERY.

PATIENT DECLARATION

I DECLARE THAT THE INFORMATION I HAVE GIVEN ON THIS FORM IS CORRECT AND COMPLETE AND I UNDERSTAND THAT IF IT IS NOT, APPROPRIATE ACTION MAY BE TAKEN.

TO ENABLE NHS NATIONAL SERVICES SCOTLAND TO CONFIRM MY ELIGIBILTY TO LAWFULLY REGISTER WITH A GP AND FOR THE PURPOSES OF PREVENTION, DETECTION, AND INVESTIGATION OF CRIME, RELEVANT INFORMATION FROM THIS FORM WILL BE DISCLOSED TO THE NHS BUSINESS SERVICES AUTHORITY, NHS NATIONAL SERVICES SCOTLAND, THE HOME OFFICE, IDENTITY AND PASSPORTS SERVICES, HM REVENUE AND CUSTOMS, THE GENERAL REGISTER OFFICE AND LOCAL AUTHORITIES.

PATIENT / REPRESENTATIVE SIGNATURE * **SIGN HERE**

REPRESENTATIVE'S NAME (IF APPLICABLE)

RELATIONSHIP TO PATIENT (IF APPLICABLE) DATE

FOR PSD ** / PRACTICE USE ONLY

PRACTICE CODE ** GP SIGNATURE

Identification seen – Do not take or retain photocopies GP REFERENCE NUMBER

BIRTH CERT. ☐ STUDENT ID CARD ☐ DRIVING LICENCE ☐ PASSPORT or HC2 Cert ☐ HOME OFFICE APP REG CARD ☐ OTHER specify

INPUT BY:	DATE:	CHECKED BY: