THE HEALTH AUTHORITY

NOTIFICATION OF CHANGE OF NAME AND/OR ADDRESS OF PATIENT

Patient/s Surname | Former Surname (if applicable)

First Name(s)

NHS No. | Date of Birth

OLD ADDRESS Tel No.	NEW ADDRESS Tel No.	
Note: The patient's medical record should be returned with this form if there is any alteration with regard to the supply of drugs or any claim for rural practice payments.	For dispensing practices: Enter 'D' here if applicable ……..	Enter any claim for rural practice payments here …… miles

Are you awaiting a hospital appointment or being seen at the hospital? ☐
(If 'YES' please tick box)

Signature of Doctor: FHS list code number:

NOTE: If more than one patient is involved, please enter particulars of remainder of family below.

Surname	First Names	Date of Birth	NHS Number