Askern Medical Practice

Askern Medical Practice
The White Wings Centre,
Spa Pool Road,
Doncaster,
DN6 0HZ

OUT OF AREA PATIENT REGISTRATION AGREEMENT

Practice Name: _____
Patient Name: _____
Date of Birth: _____
NHS Number (if known): _____

Out of Area Registration Agreement
I understand that I live outside the normal practice boundary but have requested to register with **Denaby Medical Practice** as an **Out of Area Registered Patient**.
By signing this agreement, I confirm that I understand and accept the following conditions:

1. Registration
I understand that my registration has been accepted at the discretion of the Practice following an assessment that it is clinically appropriate and safe for me to receive my primary medical care from the Practice.

2. Home Visits
I understand and accept that:

- The Practice **will not provide home visits** to my home address.
- If I become too unwell to travel to the surgery, I will need to access urgent primary care services that are local to where I live.
- The Practice may advise me to contact NHS 111 or another appropriate local service for urgent assessment or home visiting if required.

3. Routine Appointments
I understand that I will normally be expected to travel to the Practice for:

- GP appointments
- Nurse appointments
- Blood tests
- Vaccinations
- Health reviews
- Any other routine clinical services

Where clinically appropriate, appointments may also be offered by telephone, video consultation or other digital methods.

4. Emergency Care

I understand that in the event of a medical emergency I should call **999** immediately.

5. Keeping My Details Up to Date

I agree to inform the Practice promptly if:

- My address changes.
- My telephone number or contact details change.
- My health or mobility changes.
- I develop a condition that may require regular home visits or makes travelling to the Practice difficult.

6. Review of My Registration

I understand that the Practice will review my out of area registration if my clinical circumstances change.

If my registration is no longer considered safe or clinically appropriate, I understand that the Practice may ask me to register with a GP practice closer to my home in accordance with NHS regulations.

7. Patient Responsibilities

I agree to:

- Attend appointments at the Practice when requested.
- Make reasonable arrangements to travel to the surgery for routine care.
- Access urgent care services local to my home address when I am unable to attend the Practice.
- Treat Practice staff with courtesy and respect at all times.
- Keep the Practice informed of any changes that may affect my eligibility for out of area registration.

Patient Declaration

I confirm that:

☐ I have read and understood this agreement.

☐ I have had the opportunity to ask questions about my out of area registration.

☐ I understand that the Practice **will not provide home visits** to my home address.

☐ I understand that urgent home visiting services will be provided by NHS services local to where I live.

☐ I understand that my registration may be reviewed if my circumstances or healthcare needs change.

☐ I agree to comply with the conditions of my out of area registration.

Patient Signature

Name: _____

Signature: _____

Date: _____

Practice Use Only

Clinical suitability assessment completed by:

Clinician: _____

Role: _____

Date: _____

Safety netting arrangements confirmed:

☐ Patient aware of NHS 111

☐ Local urgent care arrangements discussed

☐ Patient understands no home visiting will be provided

☐ Out of Area coding applied to patient record

☐ Written patient information provided

Approved for Out of Area Registration

Signature: _____

Date: _____