HS50

NORTHERN IRELAND HEALTH AND SOCIAL SERVICES

BUSINESS SERVICES ORGANISATION

ARRANGEMENTS FOR TRANSFER OF PATIENTS

1. Details of dentist **currently** receiving Capitation/Continuing Care Payments

Surname:_____ Surgery Address:_____

Forename:_____ _____

Contract Number:_____ _____

Reason For Leaving (please circle as appropriate):
Leaving practice/transferring list only/maternity leave/resignation from Dental List/EDI software change/24 hour retirement/transfer to holding number/
other (please state reason) _____

2. Details of dentist **accepting** patients:

Surname:_____ Surgery Address:_____

Forename:_____ _____

Contract Number:_____ _____

3. Details of patients to be transferred: _____

Signature of accepting dentist:_____Date:_____

The information at 2 and 3 must be provided for each accepting dentist. The options for patients to be transferred are : "all" , surnames beginning (max 2 letters i.e. ma) " …. to …." or in age categories.

4. Other information

The Capitation/Continuing Care arrangements will transfer on _____

Please state date of your last day of employment at this surgery_____

Signature of dentist currently receiving Capitation /Continuing Care payments
_____Date: _____

If this is not the dentist currently receiving Capitation/Continuing Care payments please note the reason and your status here: _____