

**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 transfer (please circle as appropriate):**

Leaving practice/transferring list only/resignation from Dental List/EDI software change/24 hour retirement/maternity leave/ locum cover for maternity leave/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" , or a specific number of patients " .... 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: \_\_\_\_\_