**THE HERON PRACTICE**

**PATIENT ON LINE SERVICES – REQUEST FOR REGISTRATION**

**I would like to register for the following on line services:**

**Requesting repeat prescriptions □**

**Please complete the following information in full and return to a member of staff or forward to the practice by post to The Heron Practice, John Scott Health Centre, Green Lane, London N4 2NU or by email to** **NELondonicb.theheronpractice@nhs.net**

**Name:**

**………………………………………………………………………………………......................**

**Address:**

**………………………………………………………………………………………......................**

**………………………………………………………………………………………......................**

**Date of birth:**

**……………………………………………………………………………………………………….**

**Contact telephone number(s):**

**……………………………………………………………………………………………………….**

**Email address:**

**………………………………..……………………………………………………………………..**

**Your nominated pharmacy (where you would like to collect your prescription):**

**………………………………………………………………………………………………………**

**If you are completing this form on behalf of a child under 16 years of age please provide the following information:**

**Full name: ……………………………………………………………………......................**

**Relationship to child: …………………………………………………………......................**

**I understand that the Heron Practice reserves the right to decline this request for registration.**

**Signed: ………………………………………………… Date: …………............................**

**For practice use only**

**Patient EMIS number:** …………….. **Request logged by:** ……………………………

**Registration request accepted:** Yes No **Date registration details sent to patient:** …..………