**HIGHLANDS SURGERY**

**Next of Kin / Emergency Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:Mr/Mrs/Miss** |  | **DOB:** |  |
| **Address:** |  |
| **Telephone:** |  | **Mobile:** |  |
| **Email:** |  |

**NEXT OF KIN / EMERGENCY CONTACT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:Mr/Mrs/Miss** |  | **DOB:** |  |
| **Address:** |  |
| **Telephone:** |  | **Mobile:** |  |
| **Email:** |  |
| **Relationship to patient:** |  |
| **Is this person registered at Highlands Surgery?**  | **Yes** | **No** |
| **Is this person your next of kin?** | **Yes** | **No** |
| **Is this person your emergency contact?**  | **Yes** | **No** |
| **Do you give consent for this person to discuss your medical records?** | **Yes** | **No**  |

|  |  |
| --- | --- |
| **Patients Signature:** |  |
| **Print Name:** |  |
| **Date:** |  |