*Practice Name*

**Shared Care Local Enhanced Service**

Payment Claim Form

2023/2024

*Name of person*

*Completing form*

*Claiming for Qtr*

* + Start date means the first appointment with either the specialist drugs worker or GP after agreement has been reached with all parties including the patient to pursue this form of treatment

**Invoice Number: \_\_\_\_\_\_\_\_ (SDAS use only)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Initials | Date of Birth | Input date | | **Name** of Specialist Drugs Worker i.e. Shared Care Nurse only |
| Start date (**dd/mm/yy)** of  shared care treatment | Finish date **(dd/mm/yy)** of shared care treatment or ‘ongoing’ if appropriate |
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**Please complete and return to: Shared Care Payments, SDAS, 9 Westminster Way, Bridgwater, TA6 4GB or email to: Julie.barnard@turning-point.co.uk**