**Section 1: To be completed by Initiating Officer and sent to doctor**

**To:** Doctor

(Block capitals please)

**Address**:

In order to comply with the regulations or to provide the following services as indicated by Code Number (see schedule overleaf), please examine/report/attend Case Conference (delete as applicable) for the following on

**Name(s)**:

**Address**

Please send your report/confirmation of attendance at Case Conference, together with this claim form to:

**Name of Initiating Officer** Tel:

(Block capitals please)

**Initiating Officer’s signature**:  **Team Manager’s signature**:

**Section 3: To be completed by Initiating Officer and sent to Payment Office**

**To**:

(Payment Office)

**Name Of Team Manager**: **Signature**: **Date**:

(Block capitals please)

**Section 2: To be completed by Doctor and returned to Initiating Officer**

**CLAIM FOR FEES OR ALLOWANCES PAYABLE TO DOCTORS FOR SERVICES CARRIED OUT FOR LOCAL AUTHORITIES (OTHER THAN THOSE PROVIDED UNDER THE NHS)**

I declare that I have carried out the services indicated by the Code Number on the schedule overleaf, and wish to claim a fee in accordance with the National Health Service Act.

**Signature of Doctor**:

**Doctor’s name**:

(Block capitals please)

If not a General Practitioner, please give your Medical Practitioner Status:

Are you an Approved Medical Practitioner under Section 12 of the Mental Health Act? **Yes** 🞏 **No** 🞏

1. Date service provided:
2. Is this patient on your list? **Yes** 🞏 **No** 🞏
3. Does this claim refer to: Medical Examination **Only** 🞏 **Report Only** 🞏 **Both** 🞏 **Attendance At Case Conference** 🞏
4. Was the examination carried out at: **The patient’s home** 🞏 **Practice premises** 🞏 **Elsewhere** 🞏
5. Was this the patient’s: **First examination** 🞏 **Subsequent examination**  🞏
6. If you saw more than one patient, or attended a case conference, please state the duration of the session to the nearest **half** **hour**
7. If you wish to claim travelling expenses, please state the total mileage incurred: **miles/Km**
8. Details of car used: **Make** **Engine capacity**: **cc** **Registration No**

**PLEASE RETURN TO THE INITIATING OFFICER – ADDRESS IN SECTION 1 ABOVE**

The following services are the financial responsibility of the Local Authority

**01**

Medical evidence given at the request of a Court (NOT medical report required by the Directorate of Social Care and Health – see Item 07 below)

(Will be recharged by the Finance Section to the Court Authorities)

Medical fees for adoption purposes

**02**

**Code No:**

Completed forms should be forwarded to the finance team of the:

* Local Authority for work undertaken under Codes 01 and 02
* Area Team for work undertaken under Codes 03 - 10

The following services are the financial responsibility of the Primary Care Organisation

Initial and routine examination of children looked after by the Local Authority

Examination of prospective Foster Carers

Consultant Ophthalmologist’s fee for examining people with a visual disability

(Criteria for payment of fee outlined on form BD8)

Assessment under Mental Health Act – examination fee

Reports required by the Council as Court evidence and attendance of Doctor at

Court as a witness when required by the Council

Medical examination report for Community Care Assessment (use form H3 for report)

Attendance at Case Conference or any other relevant meeting at request of Social Worker

Medical Report at request of Local Authority

**03**

**04**

**05**

**06**

**07**

**08**

**09**

**10**

Section 4: To be completed by Payment Office

 £ p

Fee payable

Travel: Miles @ Checked by:

Total Paid: