**PLEASE**

**COMPLETE IN BLOCK CAPITALS**

**Claim for Medical Fees under Collaborative Arrangements**

**Mental Health Assessments**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | **To be completed by**  **Authorising Officer** | | | The examination / report under the Mental Health Act has been requested by Social Services  **Name**: **Date**:  **Job Title: Approved Mental Health Professional (Mental Health Social Worker)**  **Organisation Name & Address**: London Borough of Haringey Mental Health Services,  **Haringey Duty AMHP Services**, **Block P2, St Ann’s Hospital, St Ann’s Road, Tottenham,**  **London N15 3TH** | |
|  | **To be completed by**  **GP/Clinician** | | | I wish to claim the appropriate fee in respect of the examination / report under the Mental Health Act  **Name**: **Date**:  **Address:**  **Email address:**  **Telephone number:**  ***Please provide day time contact details in case there is a query about your claim form*** | |
| 3. | **Patient Details** | | | Details of the person examined/report compiled  **Name**: **NHS No:** **DoB**:  **Full address**: | |
| 4. | **Assessment Details** | | | **Date of assessment:**  **Time of day that assessment took place:**  **Location of assessment of patient:**  Mental Health Act Assessment  [ ] Section 2 [ ] Section 135    [ ] Section 3 [ ] No recommendation made  [ ] Section 4 [ ] Attended, no examination possible    [ ] Section 7 | |
| 5. | **Clinician** |  |  | | Capacity in which you undertook this assessment (please tick relevant box):  [ ] GP [ ] FME  [ ] Consultant [ ] S12 Approved independent practitioner  [ ] Trust contracted SPR/ST4-6 [ ] Other medical practitioner | |
| 6. | **To be completed by Clinician** |  |  | | Mileage Cars (all types of fuel) – please specify the mileage rate you are claiming  Annual Mileage up to 3500 miles (standard rate) – 54p per mile  Annual Mileage over 3500 miles (standard rate) – 18p per mile  **Address travelled from:**  No. of miles travelled      £  Amount claimed for mileage: | |
| 7. | **To be signed by**  **GP/clinician** | | | Certification  I certify that the above particulars are correct and I claim the fee of £ ……………………  ***NB: NHS NCL will only pay fees up to the limits shown on the fee structure.***  Please remit the fee to the GP/clinician address listed in Section 2 (above)  Signed: Date: | |
| 8. | **To be completed by clinician** | | | Method of payment  Please specify the method of payment that you would prefer.  Please pay my fee to my Practice Bank Account (NCL GP practices only) Name of  Practice and practice code: ……………………………………………………………………………  …………………………………………………………………………………………………………….    Please pay my fee to my personal bank account  Name of Account holder: …………………………………………………………………  Bank Account Number:...…………………………………………………………………  Sort code: .………………………………………………………………….  Please pay my fee by cheque and send to the address in section 2 | |
| 9. | **Declaration of Authorising Officer** | | | Certification on behalf Social Services/Authorised Officer  I certify that the above mentioned medical assessment was duly carried out at the request of LB Haringey and that this is a legitimate claim for which a fee is payable.  Signed:  Date:  Name: | |
| Address: Haringey **Duty AMHP Services, Block P2, St Ann’s Hospital, St Ann’s Road, Tottenham, London N15 3TH** | |

**For payment please send completed form to**

[**Beverley1.Brown@haringey.gov.uk**](mailto:Beverley1.Brown@haringey.gov.uk)