**PLEASE**

**COMPLETE IN BLOCK CAPITALS**

**Claim for Medical Fees under Collaborative Arrangements**

**Mental Health Assessments**

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| 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 claimingAnnual 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** | CertificationI 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 paymentPlease 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 accountName 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 OfficerI 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**