**Temporary services**

*GMS3/99*

*Please complete in BLOCK CAPITALS and tick* ■✔*as appropriate*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient’s details Date if claim sent electronically** |  |  |  |  |  |  |

Surname

 [ ] Mr [ ] Mrs [ ] Miss [ ] Ms

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NHSNo. |  |  |  |  |  |  |  |  |  |  |

**Date of birth** First names

Previous surname/s

|  |  |  |  |
| --- | --- | --- | --- |
| Home address |  |  | Temporary address, *if applicable* |
|  |  |
|  |  |
| Postcode | Postcode |
| Telephone number | Telephone number |

# Details of treatment should be sent to

Doctor’s name and full address

#  To be completed by the doctor

## Emergency treatment

[ ] Minor surgical operation

[ ] Treatment of fracture

[ ] General anaesthetic

[ ] Reduction of dislocation

[ ] Other

[ ] Telephone advice only

## [ ] Immediately necessary treatment

**Temporary resident**

Date of initial treatment

[ ] up to 15 days

[ ] over 15 days

[ ] Telephone advice only

[ ] Amended claim

## Contraceptive services

[ ] non-IUD [ ] IUD

## Number of night visits

**Dental haemorrhage**

[ ] Rate A [ ] Rate B

## Number of vaccinations & immunisations

fee A fee B

[ ] Rural practice payment. Distance in miles from patient’s temporary residence to my main surgery is

*I declare to the best of my belief this information is correct and I claim the appropriate payment*

*as in the SFA. An audit trail is available at the practice for inspection by the HA’s authorised officers and auditors appointed by the Audit Commission.*

## Authorised signature

Practice stamp

Name Date