

Temporary services

GMS3/99

		Please complete in BLOCK CAPITALS and tick $oldsymbol{\mathbb{L}}$ as appropriate						
Patient's details		Date if clair	— sent ε	electronically				
Mr Mrs Miss Ms	Surname			-		i	J	
Date of birth	First names							
NHS No.	Previous surname/s							
Home address		Temporary address, if applicable						
Postcode		Postcode						
Telephone number	Telephone number							
Details of treatment should be Doctor's name and full address	sent to							
To be completed by the doctor								
Emergency treatment	Immediately necessary treatment			Contraceptive s	ervices			
Minor surgical operation	Temporary resident			Number of				
Treatment of fracture	Date of initial treatment			night visits				
General anaesthetic	up to 15 da	avs		Dental haemorrhage				
Reduction of dislocation	over 15 da	,		Rate A				
Other	Telephone	Telephone advice only			& immunisations			
Telephone advice only	Amended	Amended claim		fee A		fe	e B	
Rural practice payment. Distance	in miles from pa	itient's tempor	rary reside	ence to my main	surgery	is		
I declare to the best of my belief t as in the SFA. An audit trail is avai and auditors appointed by the Au	ilable at the pra	actice for insp					rs	
Authorised signature			Practice stamp					
Name	Date							



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In case of queries, contact: at:	
Do not write on this tinted area	

Clinical records