**GP Logo**

**Paid for Private Request**

**Section A:** Requesters Information

|  |  |
| --- | --- |
| First Name(s): | Surname: |
| Date of Birth: | |
| Home Address: | |
| Contact Number: | |
| Email address: | |
| Practice Registered At:  Stratford Health Centre  The Forest Practice | |
| **Tick whichever of the following statements apply.**  I am the patient.  I have been asked to act by the patient and attach the patient’s written authorisation.  I am acting in Loco Parentis and the patient is under age sixteen, and (is incapable of understanding the request) / (has consented to me making this request)\*.  ***\*delete as appropriate.***  I have a claim arising from the patient’s death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).  ***Note:***  *If no, you must provide the patient’s written consent to release information along with photo ID, if over the age of 16.* | |

**Section B:** Summary of Request

|  |
| --- |
| Please provide a description of what you require: |
|  |

**Section C:** Please Tick Service Required

|  |  |  |
| --- | --- | --- |
| Confirmation of Registration / Private Sick Note / Private Script | £20.00 |  |
| Hepatitis B (Adult/Child) per dose | £40.00 |  |
| Private Medical Letter - e.g. (Simple Insurance claim form, Fitness to travel, housing, fitness to exercise, Holiday cancellation, simple questionnaire-not physically seeing patient, etc.) | £50.00 |  |
| Detailed Insurance Claim Form | £80.00 |  |
| Private Detailed Medical Report and where Dr does not need to see the patient | £80.00 |  |
| Private Detailed Medical Report and where Dr does need to see the patient | £130.00 |  |
| Mental Capacity Assessment Form (Patient seen at practice) | £150.00 |  |
| Mental Capacity Assessment Form (Patient seen at home) | £250.00 |  |
| Public Carriage Office (PCO) Form – Dr to see patient | £130.00 |  |
| If none of the above, please attach the form, this will need to be verified by GP/General Manager (A member of the team will contact you back within 72 hours with the fee) | |  |

**Section D:** Must Tick

|  |  |
| --- | --- |
| Routine Service: *30 Days* |  |
| Fast Track Service: 10 Working Days *(this does not include weekends or bank holidays)*  ***Additional £20.00 on above fee charged*** |  |

**UPFRONT PAYMENT - NO REFUNDS**

**Email Completed Form to:**

**If registered at Stratford Health Centre: stratford.healthcentre@nhs.net**

**If registered at The Forest Practice: theforest.practice@nhs.net**

**Section E:** Declaration

|  |  |
| --- | --- |
| Patient’s/Requester Signature: |  |
| Name of signed: |  |
| Date: |  |
| **\*Your information request will start from the date paid** | |

**Admin Staff to Complete ALL FIELDS:**

|  |  |
| --- | --- |
| Total Amount due: | £ |
| Emis Number of patient: |  |
| Patients Full Name: |  |
| Patient ID Confirmation:  Please state - *(Photo ID/ Passport/ Birth Certificate* |  |
| Amount Paid: |  |
| \*Date Paid: |  |
| Member of Staff payment taken by: |  |
| Receipt Number: |  |

**Section E:** Doctor to complete

|  |  |  |
| --- | --- | --- |
| Completed | Completed by**:** | Date: |