DEPARTMENT OF HEALTH
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01 - 407 5522 EXT
GTN (2915)

Your reference:
Our reference:

EL(89)P/62

For Action to:

Regional Health Authorities
District Health Authorities
Special Health Authorities for the Post Graduate
London Teaching Hospitals

For Information to:

Family Practitioner Committees April 1989

HC(89)12 / HC(FP)(89)6: AMENDED HOSPITAL EYE SERVICE FORMS

It has come to our attention that unfortunately the prescription sections in forms HES2 and HES(P)2, attached to HC(89)12/HC(FP)(89)6, like some of the new GOS forms, are incorrect in showing the right and left eyes in reverse. We apologise for this error, which occured at proof stage in the printing, and attach a corrected version of these forms for local duplication. We have also taken the opportunity of supplying you with a reprinted version of HES1 which should look better than the old form when copied but is not changed in any substantive detail.

Yours sincerely

PAMELA GREEN
Health Services Division 2B

Enc.

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Patient's prescription /statement

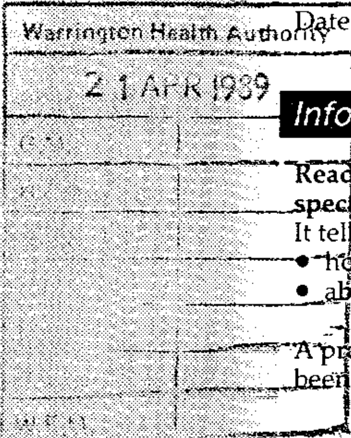
If you are 16 or over you can take this prescription to a registered optician or anyone else who supplies spectacles.
Unregistered suppliers are not allowed to sell prescription spectacles to children or to adults known to be registered blind or partially sighted. Reading glasses may be sold to adults without the need for a prescription.

Part A
To be completed by the patient

Patient's details

Surname ______________________
(Mr/Mrs/Miss/Ms)
Other names ______________________
Address ______________________
____
____

Date of birth *(if under 19)* __________



Information for patients

Read the rest of this form before you get your spectacles.
It tells you
- how to get your spectacles
- about help with the cost of your spectacles.

A prescription is valid for two years. If you have been given one, keep it in a safe place.

How to get your spectacles

If you are under 16 you must take this prescription to a registered optician.

Help with the cost of spectacles

You can get help with the cost of spectacles for any of these five reasons.
- You are under 16.
- You are a full time student under 19.
- You are getting, or are the partner of somebody who is getting
  - Income Support or • Family Credit.
- You are prescribed complex lenses.
- The Department of Social Security decides that you are on a low income.

If you think you are entitled to help for any of these reasons, complete the appropriate part of the HES(P)1.

If you do not already have a certificate AG2 or AG3 for help with NHS charges and if you think that you are entitled to because you are on a low income, ask for form AG1.

Refunds are only given by the Department of Social Security if a claim is made within one month of the date when you obtained your glasses or contact lenses.

War pensioners can also get help with spectacles if they are needed because of their pensioned disablement.

You can find out more in leaflet G11 **NHS sight test and spectacle vouchers**. You can get this leaflet from your optician or your local Social Security office.

Part B
To be completed by the Health Authority

Prescription details

RIGHT	Sph	Cyl	Axis	Prism	Base		Sph	Cyl	Axis	Prism	Base	LEFT
						Distance						
						Near						

Practitioner's report

I carried out a sight test today in accordance with the regulations with the following result:

- ☐ the prescription below was issued
- ☐ no prescription for spectacles was required
- ☐ no change was clinically necessary.
- ☐ Tick if complex lenses for voucher purposes.
- ☐ Tick if non-tolerance case.

Name and hospital address
(stamp or capitals)

Signature ______________ Date ________

Any other relevant details

NHS sight test: referral from hospital eye service

Hospital address
(stamp or capitals)

Part A
To be completed by the doctor

Doctor's declaration

I refer this hospital eye service patient to a general ophthalmic service practitioner for an eye sight test as part of the management of his/her eye condition.

Patient's hospital registration number ____________

Signature ____________ Date ________

Part B
To be completed by the patient

Patient's details

Surname ____________
(Mr/Mrs/Miss/Ms)
Other Names ____________
Address ____________

____

____

____

Date of birth *(if under 19)* ____________
Date of last NHS sight test ____________

Note
You should take this form to an optician who provides NHS sight tests. If you are able to tick one of the boxes opposite, you are already eligible for an NHS sight test. The optician will ask you to complete form GOS(ST)A. If none of the boxes apply to you, you will not be asked to complete another sight test form.

- ☐ I am under 16.
- ☐ I am a full time student under 19.

I am getting the benefit I have ticked.

- ☐ Income Support ☐ Family Credit
- ☐ I am the partner of someone who is getting the benefit I have ticked.
- ☐ Income Support ☐ Family Credit
- ☐ I have a certificate AG2 which shows I am entitled on low income grounds.
- ☐ I am registered blind/partially sighted.
- ☐ I suffer from diabetes/glaucoma.
- ☐ I have been prescribed complex lenses as defined for the purposes of the NHS voucher scheme.
- ☐ I am age 40 or over and am the parent/brother/sister/child of a person with glaucoma.

Help from the NHS spectacle voucher scheme

The scheme helps children, adults on a low income and people who need certain complex lenses. See leaflet G11 for details. If you think you may be able to get help, tick here ☐

Patient's acknowledgement of receipt of GOS(P) prescription/statement

I confirm that I have been given a completed GOS(P) (prescription/statement) following my sight test.

(If the patient is under 16 or an invalid, their parent or guardian or other person in charge of them should sign.)

Signature ____________ Date ________

Patient's declaration

I understand that if I give information that is incorrect or incomplete, action may be taken against me. I declare that the information that I have given is correct and complete to the best of my knowledge and belief.
I apply for an NHS sight test for the reason I have ticked.

(If the patient is under 16 or an invalid, their parent or guardian or other person in charge of them should sign.)

Signature ____________ Date ________

Part C

To be completed by the sight tester

Practitioner's declaration

Name and address where the sight test took place *(stamp or capitals)*

For sight test done on__________

I have ticked the boxes that apply.

- ☐ Statement issued
- ☐ New/changed prescription given
- ☐ GOS(V) given Voucher Type______________
- ☐ The patient has now shown NHS entitlement in respect of a private sight test carried out on the date
- ☐ No clinical change in prescription
- ☐ Patient was referred for an NHS sight test by the Hospital Eye Service and would not otherwise have been eligible for an NHS sight test

Name and address where payment should be sent where different

☐ I claim the appropriate fee.

Remarks *(e.g. non tolerance, early retest advised)*

Signature ________________ Date ________

Ophthalmic list number________________

Note

If the patient was not eligible for an NHS sight test, please return the form to the hospital, the address of which is shown in Part A.

Part B
To be completed by the Health Authority

Hospital Address *(stamp or capitals)*

The applicant's claim has been considered and is

☐ approved ☐ not approved

Signature ______________ Date ________

Patient's hospital registration number__________

Prescription details

VOUCHER CODE ☐

RIGHT	Sph	Cyl	Axis	Prism	Base		Sph	Cyl	Axis	Prism	Base	LEFT
						Distance						
						Near						

Part C
To be completed by the Health Authority or supplier (as appropriate)

Description of spectacles

A Enter cost if less than or equal to the voucher values or enter 'Amount exceeds voucher value'.

1st pair £______

2nd pair £______

B Enter amount appropriate to voucher value shown above. £______

- Lenses Right £______
  Left £______
- Extras (eg prisms, tints) Right £______
  Left £______
- Frame Whole £______
  Front £______
  Side £______
- Contact lenses Right £______
  Left £______
- Small glasses supplement Whole £______
  Front £______
  Side £______
- Specially made frames supplement Whole £______
  Front £______
  Side £______
- TOTAL £______

The total value of a replacement cannot exceed A or B above, whichever is less. Where a repair has been made, the amount cannot exceed the value for the appropriate part as shown in the current HN.

Supplier's declaration

Deduct any amount shown on form AG3 £______

Amount claimed £______

I have carried out the repair or replacement described opposite and claim payment for the amount shown.

Signature ______________ Date ________

Name and address of contractor to whom payment should be made.

Part D
To be completed by the patient

Patient's declaration

☐ I confirm that the repair or replacement described above has been carried out.

(If the patient is under 16 or an invalid, their parent or guardian or other person in charge of them should sign.)

Signature ______________ Date ________

NHS repair & replacement of spectacles voucher application

Part A
To be completed by the patient

Patient's details

Surname ______________________
(Mr/Mrs/Miss/Ms)
Other names ______________________
Address ______________________
____
____
____
Date of birth *(if under 19)* __________

Grounds for application

Read leaflet G11, then tick the box that applies to you. You cannot claim help if your spectacles are covered by warranty, insurance or after care service.

☐ I am under 16.

☐ I am a full time student under 19. The name and address of my school/college is
____
____
____
____

☐ I have been prescribed complex lenses as defined for the purposes of the NHS voucher scheme.

☐ I have an exemption certificate AG2.

☐ I have an AG3 which shows my voucher should be reduced by £______

☐ I am getting the benefit I have ticked.

☐ Income Support ☐ Family Credit

☐ I am the partner of someone who is getting the benefit I have ticked.

☐ Income Support ☐ Family Credit

Their name is ______________________

Their address (if different from above) is
____
____
____

The Health Authority must give approval **before** the repair/replacement is made. They must be satisfied that the loss or damage is solely due to disability, injury or illness. Please state the grounds for your claim. (YOU NEED **NOT** FILL IN THIS PART OF THE FORM IF YOU ARE UNDER 16.)

Patient's declaration

I understand that if I give information that is incorrect or incomplete, action may be taken against me. I declare that the information that I have given is correct and complete to the best of my knowledge and belief. I agree to pay the cost of the repair/replacement if I am later found not to have been entitled to help on the date of application. There is no insurance warranty or after sales care covering these spectacles.

(If the patient is under 16 or an invalid, their parent or guardian or other person in charge of them should sign.)

Signature ______________ Date ________