

GOS1W: To be used when a WGOS 1 Eye Examination takes place at an NWSSP listed practice

GOS1W Application for an NHS funded sight test

Please complete this form using black ink and in block capitals.

Part 1 PATIENT'S DETAILS

* delete as appropriate

*Mr/Mrs/Miss/Ms Surname: _____ Date of birth: / /

Previous surname (if changed within the past 12 months): _____

First names: _____

Address: _____

Postcode: _____

1 / NHS no: _____

National Insurance (NI) no: _____

2 Care Leaver

4 Pol

School/College/University*: **3** Under Care of LA

Address: Name of Local Authority

Postcode: _____

I/my* partner receive(s):

Income Support* **5** Universal Credit Income based Jobseekers Allowance*

Income related Employment and Support Allowance* Pension Credit guarantee credit*

Tax Credit and I am/we are named on a valid NHS Tax Credit Exemption Certificate

Person getting the benefit/credit* if not the patient: N.I. No: _____

Name: _____ Date of birth: / /

I am named on a valid HC2W certificate. Number: _____

I am registered severely sight impaired/sight impaired* with the Local Authority below

I suffer from diabetes/glaucoma* - my GP's details are below

I am considered to be at risk of glaucoma by an ophthalmologist at the hospital below

I am 40 or over and am the parent/brother/sister/child* of a person who has or had glaucoma

I have been prescribed complex lenses under the NHS optical voucher scheme

6 unioocular / hearing impaired / have RP

7 at risk of developing eye disease due to my ethnicity

8 at risk of glaucoma by a GH optom

GP/Local Authority/Hospital **8** State ethnicity

Address: Insert GH's practice address

Postcode: _____

Part 2 PATIENT'S DECLARATION

This is my application for an NHS funded sight test. I declare that the information given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and civil proceedings. I confirm I am entitled to an NHS funded sight test and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud.

I agree to repay the cost of the sight test if I am later found not to be entitled to it.

I am the Patient Patient's parent, carer or guardian **9**

10 Signature**:

Date: / /

Name: (in block capitals)

Address: (if different from above)

Postcode: _____

** if you are under 16 or incapable of signing, your parent, carer or other person responsible for you should sign and give their name and address.

- 1 If patient is unable to recall exact date, please indicate a timescale of when the last eye examination (NHS / Private) took place. If this is the first Sight Test, you should enter "first"
- 2 If the patient is under 18 and a Care Leaver, then the form should be annotated with the words "Care Leaver"
- 3 If the patient is in the care of a Local Authority, please annotate the form with "Under care of LA" and write the name of the Local Authority here
- 4 If the patient is a Prisoner on Leave, please annotate the form with "Pol"
- 5 If the patient is receiving Universal Credit and meet the criteria ([Help with health costs for people getting Universal Credit - NHS \(www.nhs.uk\)](https://www.nhs.uk/help/health-costs-for-people-getting-universal-credit)), please annotate the form to indicate this
- 6 If the patient is eligible as they would find losing their sight particularly difficult due to a pre-existing condition i.e. they are unioocular, they have a hearing impairment or have been diagnosed with Retinitis Pigmentosa, please note the pre-existing condition on the form
- 7 If the patient is eligible solely due to their ethnicity, please:
 1. annotate the form with "at risk of developing eye disease due to my ethnicity" and
 2. document the patient's ethnicity on the form in the GP/Local Authority/ Hospital box
- 8 If the patient is eligible solely due to being diagnosed as Ocular Hypertensive or preliminary diagnosed with COAG by an Optometrist with a glaucoma qualification, please:
 1. annotate the GOS 1 claim form with "at risk of glaucoma by a GH Optom" and
 2. Document the practice address of where the diagnosis took place on the form in the GP / Local Authority/Hospital box
- 9 The date at which the eye examination commenced needs to be visible here
- 10 Patient Signature is required from the 20.10.2023



Please note, if the patient has a HC3 form, a GOS5W form should be completed

Part 3 PRACTITIONER'S DECLARATION

I tested the sight of the person named on this form on **1**

- 2**
- The patient was referred to their GP or Ophthalmic hospital
 - A statement was issued showing no prescription was required
 - An unchanged prescription was issued
 - A new or changed prescription was issued
 - A voucher was issued: **3**

First voucher type Supplements Complex Prism Tint

Second voucher type Supplements Complex Prism Tint

**If the sight test has been conducted by the contractor only one signature is required at the bottom of this form*

To be completed by the Practitioner who has conducted the sight test

Practitioner's signature: _____

Practitioner's name: _____
(in block capitals)

Date: _____ / _____ / _____

Ophthalmic / Supplementary list number: _____

I claim the current NHS sight test fee **4**

In the case of a re-test at less than the standard interval, please specify the appropriate code.

Practice address where sight test took place: <i>(in capitals/stamp)</i>	Address (if different) where payment should be sent: <i>(in capitals/stamp)</i>

DECLARATION

I claim the payment shown above under the NHS General Ophthalmic Services Regulations. I confirm that the information given on this form is correct and complete and that this is the original form as signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and or civil proceedings. I consent to the disclosure or relevant information for the purpose of verification or this claim and in relation to the prevention and detection of fraud.

To be completed by the contractor or authorised signatory

Signature: _____ **5**

Name: _____
(in block capitals)

Date: _____ / _____ / _____

Ophthalmic list number: _____

Contractor's name and address: *(in capitals/stamp)*

- 1** This date should correspond to the date at which the eye examination was completed
NOTE: This may differ to the date in part 2 of the form e.g. when a patient has to return as the test had to stop due to a fire alarm or patient became unwell during the eye examination.
- 2** The Optom / OMP should tick all boxes that are relevant to the outcome of the eye examination
- 3** The voucher type(s) need to be complete by the Optom / OMP at the end of the eye examination and at time of issuing the voucher
- 4** Please note change to early recall codes (see below)
- 5** This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so. [Authorised Signatory Form July 2020.docx \(live.com\)](#)

WGOS 1 Eye Examination Health Examination Early Test Codes

Early Test Codes	Reason
1	Patient was identified at the last WGOS 1 Eye Examination / Private Sight Test as being at risk of changes to optical prescription
2	Patient has an ocular pathology likely to worsen, e.g., cataracts and vision is borderline for driving; binocular vision anomalies, etc.
3	Patient that has presented with visual symptoms who following triage by the practice is not eligible for a WGOS 2: Band 1 but requires further examination
4	Patient has been identified in WGOS protocols as needing to be seen more frequently because of ocular / health / behavioural risk factors
5	Patient has been referred by a medical practitioner for a WGOS 1 eye examination
6	A second WGOS 1 Eye Examination is necessary as the patient is unable to tolerate their new spectacles
7	Other circumstances requiring clinical investigation which are not outlined above

NOTE Whilst there is complete freedom to exercise clinical judgement in individual cases, it is not appropriate to apply a blanket recall interval to all patients within a category e.g. all patients over the age of 70 or patients with diabetes are automatically placed on 12 months recalls. Over-frequent WGOS 1 Eye Examinations could cause the Health Board to question whether a Performer / Contractor should remain on the Wales Ophthalmic List.

GOS6W: To be used when a WGOS 1 Eye Examination takes place outside of a NWSSP listed practice

GOS6W Application for a mobile NHS funded sight test

Please complete this form using black ink and in block capitals.

Part 1 PATIENT'S DETAILS

* delete as appropriate

*Mr/Mrs/Miss/Ms Surname: _____ Date of birth: / /
 Previous surname: (if changed within the past 12 months) _____
 First names: _____
 Address: _____
 Postcode: _____

*if known

Date of last sight test: / 1 / NHS no: _____
 National Insurance (NI) no: _____

I cannot attend a practice unaccompanied for a sight test because: 2

Tick all boxes that apply to you

I am 60 or over I am under 16* I am a full time student aged 16, 17, or 18* and attend: 3 **Care Leaver**

5 **Pol** School/College/University*: 4 **Under Care of LA**
 Address: **Name of Local Authority**
 Postcode: _____

I/my partner receive(s):

Income Support **Universal Credit** 6 Income based Jobseekers Allowance*
 Income related Employment and Support Allowance Pension Credit guarantee credit*
 Tax Credit and I am/we are named on a valid NHS Tax Credit Exemption Certificate*

Person getting the benefit/credit* if not the patient: N.J. No: _____
 Name: _____ Date of birth: / /

I am named on a valid HC2W certificate. Number: _____
 I am registered severely sight impaired/sight impaired* with the Local Authority below
 I suffer from diabetes/glaucoma* - my GP's details are below
 I am considered to be at risk of glaucoma by an ophthalmologist at the hospital below
 I am 40 or over and am the parent/brother/sister/child* of a person who has or had glaucoma
 I have been prescribed complex lenses under the NHS optical voucher scheme 8

7 **unilateral / hearing impaired / have RP** Local Authority: **at risk of developing eye disease due to my ethnicity**
 State: **at risk of glaucoma by a GH Optom** State ethnicity
 Insert GH's practice address Postcode: _____

9

Part 2 PATIENT'S DECLARATION

This is my application for a mobile NHS funded sight test. I declare that the information given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and or civil proceedings. I confirm I am entitled to a mobile NHS funded sight test and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud. I agree to repay the cost of the sight test if I am later found not to be entitled to it.

** If you are under 16 or incapable of signing, your parent, carer or other person responsible for you should sign and give their name and address.

I am the Patient Patient's parent, carer or guardian 11

Signature**: _____ Date: / /

Name: (in block capitals) _____ 10
 Address: (if different from above) _____
 Postcode: _____

- 1 If patient is unable to recall exact date, please indicate a timescale of when the last eye examination (NHS / Private) took place. If this is the first Sight Test, you should enter "first"
- 2 The reason for requiring the mobile service (i.e specific illness / disability) must be recorded on the GOS6W form and the clinical records. Terms like 'housebound', 'immobile', 'wheelchair-bound' or 'resident of a home' are insufficient
- 3 If the patient is under 18 and a Care Leaver, then the form should be annotated with the words "Care Leaver"
- 4 If the patient is in the care of a Local Authority, please annotate the form with "Under care of LA" and write the name of the Local Authority here
- 5 If the patient is a Prisoner on Leave, please annotate the form with "PoL"
- 6 If the patient is receiving Universal Credit and meet the criteria ([Help with health costs for people getting Universal Credit - NHS \(www.nhs.uk\)](https://www.nhs.uk/help/health-costs-for-people-getting-universal-credit)), please annotate the form to indicate this
- 7 If the patient is eligible as they would find losing their sight particularly difficult due to a pre-existing condition i.e. they are unioocular, they have a hearing impairment or have been diagnosed with Retinitis Pigmentosa, please note the pre-existing condition on the form
- 8 If the patient is eligible solely due to their ethnicity, please:
 1. annotate the form with "at risk of developing eye disease due to my ethnicity" and
 2. document the patient's ethnicity on the form in the GP/Local Authority/ Hospital box
- 9 If the patient is eligible solely due to being diagnosed as Ocular Hypertensive or preliminary diagnosed with COAG by an Optometrist with a glaucoma qualification, please:
 1. annotate the GOS 1 claim form with "at risk of glaucoma by a GH Optom" and
 2. Document the practice address of where the diagnosis took place on the form in the GP / Local Authority/Hospital box
- 10 Patient Signature is required from the 20.10.2023
- 11 The date at which the eye examination commenced needs to be visible here



Please note, if the patient has a HC3 form, a GOS5W form should be completed

GOS6W

Part 3 PRACTITIONER'S DECLARATION

I tested the sight of the person named on this form on Date: / / 1

I have made a domiciliary visit to conduct this sight test to one patient at the address in Part 1
 I have made a domiciliary visit to several patients at the address in Part 1

This patient was the:

1st patient at the address
 2nd patient at the address
 3rd or subsequent patient at the address

The patient was referred to their GP or Ophthalmic hospital

A statement was issued and no prescription was required
 An unchanged prescription was issued
 A new or changed prescription was issued 5
 A voucher was issued:

First voucher type: Supplements Complex Prism Tint
 Second voucher type: Supplements Complex Prism Tint

To be completed by the Practitioner who has conducted the sight test:

Practitioner's Signature: _____
 Practitioner's name: (in block capitals) _____ Date: / /
 Ophthalmic / Supplementary list number: _____

CLAIM

I claim:

the current NHS sight test fee
 the domiciliary fee for:

1st patient at the address
 2nd patient at the address
 3rd or subsequent patient at the address

Total claim for sight test: £ _____

In the case of a re-test at less than the standard interval, please specify the appropriate code: _____ 7

Address where sight test took place: (in capitals/stamp)	Address of contractor who provided sight test: (in capitals/stamp)	Address (if different) where payment should be sent: (in capitals/stamp)
8		

I claim the payment shown above under the NHS General Ophthalmic Services Regulations. I declare that the information given on this form is correct and complete and that this is the original form as signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of this claim and in relation to the prevention and detection of fraud.

To be completed by the contractor or authorised signatory.

Signature: _____	Contractor's name and address: (in capitals/stamp) _____ 9
Name: (in block capitals) _____	
Date: / /	
Ophthalmic list number: _____	

If the sight test has been conducted by the contractor only one signature is required at the bottom of this form

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- 1 This date should correspond to the date at which the eye examination was completed
 NOTE: This may differ to the date in part 2 of the form e.g. when a patient has to return as the test had to stop due to a fire alarm or patient became unwell during the eye examination.
- 2 3 8 To be paid the correct fee, please complete this section
- 4 The Optom / OMP should tick all boxes that are relevant to the outcome of the eye examination
- 5 The voucher type(s) need to be complete by the Optom / OMP at the end of the eye examination and at time of issuing the voucher
- 6 In order to be paid the correct fee, please ensure that this section is accurately completed
- 7 Please note change to early recall codes (see below)
- 9 This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so.
[Authorised Signatory Form July 2020.docx \(live.com\)](#)

WGOS 1 Eye Examination Health Examination Early Test Codes

Early Test Codes	Reason
1	Patient was identified at the last WGOS 1 Eye Examination / Private Sight Test as being at risk of changes to optical prescription
2	Patient has an ocular pathology likely to worsen, e.g., cataracts and vision is borderline for driving; binocular vision anomalies, etc.
3	Patient that has presented with visual symptoms who following triage by the practice is not eligible for a WGOS 2: Band 1 but requires further examination
4	Patient has been identified in WGOS protocols as needing to be seen more frequently because of ocular / health / behavioural risk factors
5	Patient has been referred by a medical practitioner for a WGOS 1 eye examination
6	A second WGOS 1 Eye Examination is necessary as the patient is unable to tolerate their new spectacles
7	Other circumstances requiring clinical investigation which are not outlined above

NOTE Whilst there is complete freedom to exercise clinical judgement in individual cases, it is not appropriate to apply a blanket recall interval to all patients within a category e.g. all patients over the age of 70 or patients with diabetes are automatically placed on 12 months recalls. Over-frequent WGOS 1 Eye Examinations could cause the Health Board to question whether a Performer / Contractor should remain on the Wales Ophthalmic List.

GOS5W: To be used when a patient has a HC3 certificate irrespective of where the sight test took place

GOS5W Help with the cost of a private sight test

If you (or your partner) are named on a valid HC3W certificate for partial help with health costs you may be able to get help with the cost of a private sight test. For more information see leaflet HC11W - "Help with Health Costs", which can be obtained by calling 0845 603 1108. If you think you might be entitled to help with the cost of your glasses, ask when you have your sight test.

Please complete this form using black ink and in block capitals.

Part 1 PATIENT'S DETAILS

* delete as appropriate

*Mr/Mrs/Miss/Ms Surname: _____ Date of birth: / /

Previous surname: (if changed within the past 12 months) _____

First names: _____

Address: _____

Postcode: _____

* if known

Date of last sight test: / 1 / NHS no: _____

National Insurance (NI) no: _____

Reason for patient's entitlement to vouchers

If my partner are named on a valid HC3W certificate, number: 2 _____

- showing (at box A) that I have to pay up to £ _____ for a private sight test.

I will pay up to the amount above (plus any difference between the NHS sight test fee and the cost of my sight test) provided my sight test costs more than the NHS sight test.

Note: The person who tests your sight can tell you the NHS sight test fee. This is also in leaflet HC12W "NHS charges and optical voucher values". This is available from the following website: www.wales.gov.uk/healthforms or by telephoning 0845 603 1108.

I cannot attend a practice unaccompanied for a sight test because:

3 _____

Part 2 PATIENT'S DECLARATION

This is my application for help with the cost of a private sight test. I declare that the information given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and or civil proceedings. I confirm proper entitlement to help with the cost of a private sight test and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud.

I agree to repay the amount granted if I am later found not to be entitled to it.

I am the patient patient's parent, carer or guardian.

Signature*: 5 _____ 4 Date: / /

Name: (in block capitals) _____

Address: (if different from above) _____

Postcode: _____

** If you are under 16 or incapable of signing, your parent, carer or other person responsible for you should sign and give their name and address.

- 1 If patient is unable to recall exact date, please indicate a timescale of when the last eye examination (NHS / Private) took place. If this is the first Sight Test, you should enter "first"
- 2 Enter the details directly from the HC3 certificate
- 3 If the eye examination takes place outside of a NWSSP approved practice, the reason for requiring the mobile service (i.e specific illness / disability) must be recorded on the GOS5W form and the clinical records. Terms like 'housebound', 'immobile', 'wheelchair-bound' or 'resident of a home' are insufficient
- 4 The date at which the eye examination commenced needs to be visible here
- 5 Patient Signature is required from the 20.10.2023

Part 3 PRACTITIONER'S DECLARATION

I tested the sight of the person named on this form on ①

② The patient was referred to their GP or Ophthalmic hospital
 A statement was issued showing no prescription was required
 An unchanged prescription was issued
 A new or changed prescription was issued
 A voucher was issued ③

First voucher type: Supplements Complex Prism Tint
 Second voucher type: Supplements Complex Prism Tint

This patient was the:
 1st patient at the address
 2nd patient at the address
 3rd or subsequent patient at that address

④

To be completed by the Practitioner who has conducted the sight test

Practitioner's signature:
 Practitioner's name: (in block capitals)
 Date: / /
 Ophthalmic / Supplementary list number:

if the sight test has been conducted by the contractor only one signature is required at the bottom of this form

CLAIM

I claim for a sight test:

Lower of private charge or NHS sight test fee	£	(1)
Lower of private charge or NHS domiciliary visit fee (where appropriate)	£	(2)
Maximum claimable in respect of sight test (sum of 1+2)	£	(3)
Patient's contribution as shown by box A of HC3W	£	(4)
Total claim in respect of sight test (3 minus 4)	£	⑤

Address where sight test took place: (in capitals/stamp)	Address of contractor who provided sight test: (in capitals/stamp)	Address (if different) where payment should be sent: (in capitals/stamp)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

⑥

I claim the payment shown above under the NHS General Ophthalmic Services Regulations. I declare that the information given on this form is correct and complete and that this is the original form as signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and or civil proceedings. I consent to the disclosure or relevant information for the purpose of verification or this claim and in relation to the prevention and detection of fraud.

To be completed by the contractor or authorised signatory.

Signature: <input type="text"/>	Contractor's name and address: (in capitals/stamp) ⑦
Name: <input type="text"/> (in block capitals)	
Date: <input type="text"/> / <input type="text"/> / <input type="text"/>	
Ophthalmic list number: <input type="text"/>	

- ① The date at which the sight test was completed should be visible here. This may differ to the date in part 2 of the form e.g. when the test could not be completed as the patient became unwell during the eye exam
- ② The Optom / OMP should tick all boxes that are relevant to the outcome of the eye examination
- ③ The voucher type(s) need to be complete by the Optom / OMP at the end of the eye examination and at time of issuing the voucher
- ④ If the eye examination took place outside of a NWSSP approved practice, in order to be paid the correct fee, please complete this section
- ⑤ ⑥ To be paid the correct fee, please ensure that this section is accurately completed
- ⑦ This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so. [Authorised Signatory Form July 2020.docx \(live.com\)](#)



Whilst there is no place to record an early recall code on the GOS5W form, the Optom / OMP must ensure that an eye examination is clinically necessary

GOS3W: To be issued when the patient is eligible for an NHS funded optical appliance

GOS3W NHS optical voucher and patient's statement

To get your glasses/contact lenses, fill in, sign and date Part 2 when you order them from the optician of your choice. Sign and date Part 4 overleaf to confirm that you have received them. Please complete this form using black ink and in block capitals.

Part 1 PATIENT'S DETAILS

*delete as appropriate
 *Mr/Mrs/Miss/Ms Surname: _____ Date of birth: / /
 Previous surname (if changed within the past 12 months): _____
 First names: _____
 Address: _____
 Postcode: _____
 Date of this prescription: / / NHS no: _____
 National Insurance (NI) no: _____

To be completed by the practitioner at your sight test

1 First voucher type: 2 Supplements Complex Prism Tint
 Second voucher type: Supplements Complex Prism Tint

R	Sph	Cyl	Axis	Prism	Base	Sph	Cyl	Axis	Prism	Base	LEFT
I G H T						Distance					
						Near					

3 If applicable
 Local Health Board receiving relevant GOS1W or GOS6W: _____
 Practitioner's name: (print) _____ Ophthalmic/Supplementary list number: _____
 Signature: _____ Date: / /

Part 2 PATIENT'S DECLARATION

If your address has changed from that shown above enter in your new one

My name and address are as shown above. I wish to order glasses/contact lenses* and I am entitled to use the above voucher today because:

I am under 16 I am a full time student aged 16, 17, or 18 and attend: 

5 Care Leaver School/College/University*: Under Care of LA 6
 Address: Name of Local Authority
 Postcode: _____

7 PoL

Tick any box which applies to you. These circumstances must apply on the date you order your glasses or contact lenses

My* partner receive(s):
 Income Support Universal Credit 8
 Income related Employment and Support Allowance Income based Jobseekers Allowance
 Pension Credit guarantee credit
 Tax Credit and I am/We are named on a valid NHS Tax Credit Exemption Certificate

Person getting the benefit/credit* if not the patient: N.I. No: _____
 Name: _____ Date of birth: / /

I am named on a valid HC2W HC3W - certificate number: _____
 The HC3W (box B) shows that the voucher value will be reduced by: £ _____

I have been prescribed complex lenses under the NHS optical voucher scheme.

I declare that the information given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and/or civil proceedings. I confirm I am entitled to an NHS optical voucher and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud. I agree to repay the voucher value if I am later found not to be entitled to it.

9 I am the patient patient's parent, carer or guardian.

10 Signature**: _____ Date: / /

Name: (in block capitals) _____
 Address: (if different from above) _____
 Postcode: _____

** if you are under 16 or incapable of signing, your parent, carer or other person responsible for you should sign and give their name and address.

- 1 If a GOS3W form is presented for dispensing and the prescription is not written in the form which gives the highest spherical power, the prescription should be transposed. If the transposed prescription then provides a higher-value voucher and benefits the patient, the voucher type should be amended on the form and annotated with "FPN 713"
- 2 Prisms and tints can only be prescribed by the OO / OMP who have performed the sight test and only when they are prescribing a powered lens. They cannot be added to the voucher at the time of dispensing
- 3 If the spectacle prescription needs to be altered as the frame being dispensed sits at different back vertex distance to that recorded at the time of the sight test, the GOS3W or HES 3 form should be annotated with the words 'BVD change' in the margin. If the change requires a higher voucher band, the GOS3W or HES voucher form should be annotated accordingly
- 4 If the patient was not issued a prescription at the time of the sight test because they were not eligible, but are now eligible for a voucher (see manual), the practitioner should copy the prescription to the prescription box and write 'transcribed by' and enter their name and list number and sign and date the form indicating the date of the prescription on which the GOS3W will be based
- 5 If the patient is under 18 and a Care Leaver, then the form should be annotated with the words "Care Leaver"
- 6 If the patient is in the care of a Local Authority, please annotate the form with "Under care of LA" and write the name of the Local Authority here
- 7 If the patient is a Prisoner on Leave, please annotate the form with "PoL"
- 8 If the patient is receiving Universal Credit and meet the criteria, please annotate the form to indicate this
- 9 The date at which the spectacles were ordered
- 10 Patient Signature is required from the 20.10.2023



Please note, to be eligible the patient must fall into one of the categories listed in Part B of the GOS3W form and the Optom / OMP considers that a new pair is required as there has either been a significant clinical change in spectacle prescription or the current spectacles are no longer fitted or serviceable through fair wear and tear

GOS4W: To be used when claiming for repairing / replacing an NHS funded pair of spectacles

GOS4W NHS optical repair/replacement voucher application form

You cannot get help if your glasses/contact lenses are covered by warranty, insurance or after care service. If they are not, and you are under 16, you will get a voucher towards the cost of a repair or replacement. If you are aged 16 or over and are in one of the categories shown in Part 1 you must satisfy the Local Health Board that your glasses or contact lenses were lost or damaged because you were ill. You can wait for the Local Health Board to approve your claim before you get the repair/replacement done or you can pay and claim a refund. You can only have a refund if your Local Health Board agrees. **Please complete this form using black ink and in block capitals.**

Part 1 PATIENT'S DETAILS

* delete as appropriate

*Mr/Mrs/Miss/Ms Surname: _____ Date of birth: / / _____

Previous surname (if changed within the past 12 months): _____

First names: _____

Address: _____

Postcode: _____

*if known

Date of last sight test: / 1 / _____ NHS no*: _____

National Insurance (NI) no*: _____

Tick any box which applies to you. These circumstances must apply on the date you order your glasses or contact lenses.

I am under 16 (go to Part 2)

I am a full time student aged 16, 17, or 18 and attend: **2 Care Leaver**

3 Under Care of LA

4 PoL

School/College/University*: _____

Address: _____

Name of Local Authority: _____

Postcode: _____

My* partner receive(s):

Income Support **5 Universal Credit**

Income related Employment and Support Allowance

Tax Credit and I am/we are named on a valid NHS Tax Credit Exemption Certificate

Income based Jobseekers Allowance

Pension Credit guarantee credit

Person getting the benefit/credit* if not the patient: N.I. No: _____

Name: _____ Date of birth: / / _____

I am named on a valid HC2W HC3W - certificate number: _____

The HC3W (box 3) shows that the voucher value will be reduced by: £ _____

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

I have explained below* how the loss or damage happened.

6

Part 2 PATIENT'S DECLARATION

I confirm there is no insurance warranty or after sales service covering my lost or damaged glasses or contact lenses. I declare that the information I have given on this form is correct and complete. I understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and/or civil proceedings. I confirm I am entitled to an NHS optical repair/replacement voucher and I consent to the disclosure of relevant information for the purpose of checking this and in relation to the prevention and detection of fraud. I agree to repay the voucher value if I am later found not to be entitled to it.

I am the patient patient's parent, carer or guardian. **7**

Signature**: _____ **8** Date: / / _____

Name: (in block capitals) _____

Address: (if different from above) _____

Postcode: _____

- 1 The date of the last WGOS 1 eye examination should be documented here
- 2 If the patient is under 18 and a Care Leaver, then the form should be annotated to demonstrate this
- 3 If the patient is in the care of a Local Authority, please annotate the form with "Under care of LA" and write the name of the Local Authority here
- 4 If the patient is a Prisoner on Leave, please annotate the form with "PoL"
- 5 If the patient is receiving Universal Credit and meet the criteria, please annotate the form to indicate this
- 6 The reason for repair / replacement must be explained here. The explanation must also be visible in the clinical record
- 7 The date at which the patient requests funding to repair / replace their NHS funded spectacles
- 8 Patient Signature is required from the 20.10.2023



Children under the age of 16, full time students aged 16, 17 or 18, care leavers under the age of 18 and those who are under 18 and are in the care of a Local Authority are entitled to repairs / replacements on their most recent NHS funded spectacles in consequence of loss or damage, without having to obtain prior consent from NWSSP.

All other patients are only eligible for repairs or replacements on their most recent NHS funded spectacles if they are still eligible for NHS funded spectacles and with prior approval from NWSSP. Approval can be sought by emailing nwssp-primarycareservices@wales.nhs.uk with the patient details, exemption reason and medical reason for loss/damage.

GOS4W

Part 3 TO BE COMPLETED BY THE LOCAL HEALTH BOARD

The applicant's claim has been considered and is:
 approved not approved

Full name:
Signature:
Date: / /

LHB name and address: (stamp or write in capitals)

Part 4 PATIENT'S DECLARATION

I confirm that my glasses/ contact lenses have been repaired replaced
 I am the patient patient's parent, carer or guardian

Signature*¹: ²
 Date: / /

Part 5 SUPPLIER'S DECLARATION

In accordance with the prescription and details below I have:
 repaired replaced the glasses/contact lenses* for the person named at Part 1 of this form.

R	Sph	Cyl	Axis	Prism	Base	Sph	Cyl	Axis	Prism	Base	L	E	F	T

Voucher type: Supplements Complex Prism Tint

Voucher value appropriate to the above prescription

Parts: Lens/C.L.* Right Left Both
 Frame Front Side Whole

Supplements:
 Complex CNSL
 Prism
 Tint
 Small glasses SFC ⁴

£ (1)
 £ (2)
 £ (3)
 £ (4)
 £ (5)
 £ (6)
 £ (7)
 £ (8)
 £ (9)
 £ (10)
 £ (11)

CLAIM

I claim under the NHS optical voucher scheme:
 Voucher value plus any supplement(s) (sum of 1+(4+5+6+7))
 or part(s) at current prices plus any supplement(s) (sum of (2+3)+(4+5+6+7))
 or actual retail cost, if less
 Patient's contribution as shown by box B of certificate HC3W (if applicable)
 Total claim (8 or 9 or 10 – whichever is the lowest, minus 11)

I claim the payment shown above under the NHS (Optical Charges and Payments) Regulations 1997. I declare that the information given on this form is correct and complete and that this is the original form as signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and/or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of this claim and in relation to the prevention and detection of fraud.

Supplier's name:
Supplier's signature: ⁶
Date: / /

Supplier's name and address: (in capitals/stamps)

- 1 This is the date at which the patient has collected the spectacles that have been repaired / replaced
- 2 Patient Signature is required from the 20.10.2023
- 3 If a 'Child Non-Stock Lens Supplement' is being claimed, please cross out the word 'Complex' and replace with 'CNSL'
 NOTE: The supplement can only be claimed if there is evidence to demonstrate that the patient has received a lens that improves the cosmetic appearance e.g., surfaced lenses, smaller blank sizes, higher index lenses etc.)
- 4 If a Special Facial Characteristics Supplement is being claimed, please cross out the words 'Small glasses' and replace with 'SFC'
 NOTE: The records must evident why this supplement is being claimed as well as demonstrating that a special spectacle frame has been manufactured specifically for the patient.
- 5 The Optom / OMP should tick all boxes that are relevant to the outcome of the eye examination
- 6 This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so. [Authorised Signatory Form July 2020.docx \(live.com\)](#)



A GOS4W cannot be used to repair / replace contact lenses

WECS 1: To be used when undertaking any WGOS 2 services

WECS 1 **WALES EYE CARE SERVICE (WECS)**



EYE HEALTH EXAMINATION WALES APPLICATION FORM
Complete this form using black ink and in block capitals



Part 1. – Patient's Details and Declaration

Mr / Mrs / Miss / Ms / Dr / Other Male / Female D.O.B: _____

Surname: _____ First Names: _____

Address: _____

_____ Postcode: _____ Tel Number: _____

Doctor's name: _____ Surgery Address: _____

1 Stating your ethnicity helps to determine your risk of eye disease. Please choose one section and tick the box that best describes your ethnic background:

White Welsh / English / Scottish / N Irish / British Irish Other

Asian / Asian British Indian Pakistani Chinese Bangladeshi Other Asian

Black / African / Caribbean / Black British African Caribbean Other Black

Mixed / multiple White and Black Caribbean White and Black African

White and Asian Other mixed / multiple

Other ethnic group Arab Other State _____

Eligible for Band 1 at risk of eye disease due to ethnic background

I understand and accept that if I withhold information or provide false or misleading information I may be liable to prosecution and or civil proceedings. I confirm that I am entitled to this EHEW and I consent to the disclosure of relevant information for the purpose of checking this; planning and administering the service; and in relation to the prevention and detection of fraud. I agree to pay the cost of the service if I am later found not to be entitled to it.

Patient's / Guardian's signature: **5** REMOTE _____ **2** Date: _____

Guardian's name and address: _____

Part 2. – Optometrist / OMP Declaration: I certify that I carried out a:

4 **BAND 1: EYE HEALTH EXAMINATION WALES (EHEW) The patient:**

Has an acute eye problem and I have offered them an appointment within 24hrs of request

~~Is Unilateral Is hearing impaired Has RP Other~~

Was referred by other healthcare professional, please indicate: Optom GP Pharmacist

Ophthalmologist Other

~~Is at risk of eye disease due to ethnic background (see above)~~

Needs investigations to comply with WG agreed protocols / guidelines

DRSSW OHT / glaucoma suspect monitoring Dry AMD Other

BAND 2: FURTHER INVESTIGATION / EXAMINATIONS

Cataract pre-op refinement Cataract Post-op conversion OHT / glaucoma refinement

Cycloplegia on a child Other

BAND 3: EHEW FOLLOW-UP EXAMINATION

Follow-up from previous band 1 Post-op cataract Other

- 1** If the patient refuses to state their ethnicity, a claim can be made. In this circumstance, the contractor should write 'prefer not to say' next to the ethnicity categories
- 2** The date at which the examination commenced needs to be visible here
- 3** Where there is more than one possible reason for completing an EHEW examination, the Optometrist / OMP / CLO should use their clinical judgement to decide the most appropriate box to tick i.e. only ONE box should be ticked
- 4** If the WGOS 2 took place outside of a NWSSP approved practice, in order to be paid the correct fee, please annotate the form with the words "I claim the Mobile fee for *[insert whether it's the first, second or subsequent]* patient at the address"
- 5** Patient Signature is required from the 20.10.2023
Where WGOS 2 is delivered remotely the patient cannot give signature. In this case, please annotate as "REMOTE"



Please note, a WECS 1 should **NOT** be submitted for any WGOS 1 activities

I will take the following action: Please tick **all** that apply.

Advice / Regular routine review	<input type="checkbox"/>	Referred HES-Routine	<input type="checkbox"/>	Report to GP (required in all cases within 7 days)	<input type="checkbox"/>
Follow-up with Band 3	<input type="checkbox"/>	Referred HES-Urgent (if applicable)	<input type="checkbox"/>	Report to HES	<input type="checkbox"/>
Other Follow up	<input type="checkbox"/>	Referred HES-Emergency	<input type="checkbox"/>	Report to DRSSW	<input type="checkbox"/>
Foreign body or eyelash removal	<input type="checkbox"/>	Referred GP to prescribe medication	<input type="checkbox"/>	Report to other	<input type="checkbox"/>
Rx issued	<input type="checkbox"/>	Referred to GP for other	<input type="checkbox"/>		<input type="checkbox"/>
Voucher issued	<input type="checkbox"/>	Referred to LVSW	<input type="checkbox"/>	Referred to other professional	<input type="checkbox"/>
Drugs advised / supplied –					
Dry eye treatment	<input type="checkbox"/>	Chloramphenicol	<input type="checkbox"/>	Anti-allergy drops	<input type="checkbox"/>
Other drug	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Please tick all symptoms that apply and all findings / conditions that are relevant to the reason for, or outcome of, the EHEW.

Symptoms		Findings / conditions	
None	<input type="checkbox"/>	No clinical abnormality	<input type="checkbox"/>
Acute vision problem	<input type="checkbox"/>	Dry eye / MGD	<input type="checkbox"/>
Chronic vision problem	<input type="checkbox"/>	Wet AMD	<input type="checkbox"/>
Red eye	<input type="checkbox"/>	Dry AMD	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	Eyelid, eyelash, lacrimal, orbit	<input type="checkbox"/>
Floater	<input type="checkbox"/>	Foreign body / other trauma	<input type="checkbox"/>
Eye pain / discomfort	<input type="checkbox"/>	Conjunctiva	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Cornea / sclera	<input type="checkbox"/>
Diplopia	<input type="checkbox"/>	Cataract / lens / IOL / PCO	<input type="checkbox"/>
Other (detailed below)	<input type="checkbox"/>	Iris / ciliary body	<input type="checkbox"/>
		Optic nerve / visual pathway / migraine	<input type="checkbox"/>
		Ocular muscle / binocular / accommodation / refraction conditions – adults	<input type="checkbox"/>
		Ocular muscle / binocular / accommodation / refraction conditions – children	<input type="checkbox"/>
		Post op complications / disorders not classified elsewhere	<input type="checkbox"/>

To be completed by the optometrist who has conducted this examination. I understand that if I give information that is incorrect or incomplete, action may be taken against me. I consent to the disclosure of relevant information for the purpose of verification of this claim and for the prevention and detection of fraud.

Signature	Optometrists name and practice address (Capitals or Stamp):
Date: / /	
Ophthalmic / Supplementary List number:	

To be completed by contractor or authorised signatory. I claim the current fee for this patient under the Wales Eye Care Service. I declare that the information given on this form is correct and complete and that this is the original form signed by the patient. I understand and accept that if I withhold information or provide false or misleading information, disciplinary action may be taken against me and I may be liable to prosecution and or civil proceedings. I consent to the disclosure of relevant information for the purpose of verification of this claim and in relation to the prevention and detection of fraud.

Signature	Contractor's name and address (Capitals or Stamp):
Date: / /	
Ophthalmic List number:	Address where payment should be sent: (if different from contractor address)

1

1 To facilitate clinical audit, the Optom / OMP / CLO must ensure that have ticked at least one box in each of the sections. Multiple boxes can be ticked to capture all presenting symptoms and clinical findings / outcomes

2 This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so. [Authorised Signatory Form July 2020.docx \(live.com\)](#)

3 If the WGOS 2 took place outside of a NWSSP approved practice, in order to be paid the correct fee, please annotate the form with the words "I claim the Mobile fee for [insert whether it's the first, second or subsequent] patient at the address"

*If the eye examination has been conducted by the contractor, only one signature is required at the bottom of this form

2

3

I claim the Mobile fee for the 1st/2nd / subsequent patient at the address



The GP should be notified when a WGOS 2: Band 1,2 or 3 have been completed