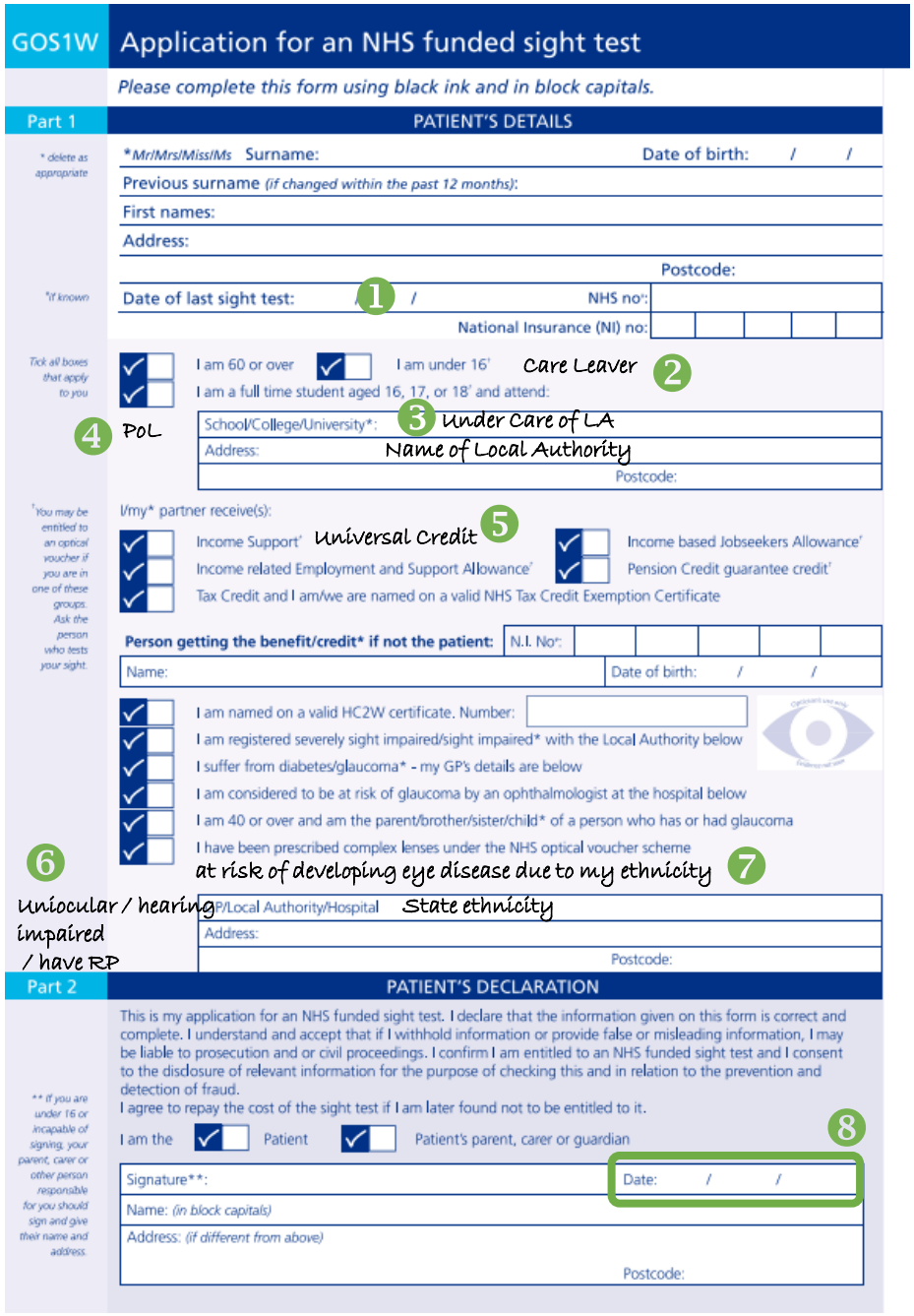
GOS1W: To be used when a WGOS 1 Eye Examination takes place at an NWSSP listed practice



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:

*If known

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

National Insurance (NI) no:

Tick all boxes that apply to you

☑ I am 60 or over ☑ I am under 16' Care Leaver 2

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

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

Address: Name of Local Authority

Postcode:

'You may be entitled to an optical voucher if you are in one of these groups. Ask the person who tests your sight.

I/my* partner receive(s):

☑ Income Support' Universal Credit 5 ☑ 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 at risk of developing eye disease due to my ethnicity 7

Uniocular / hearing impaired / have RP

GP/Local Authority/Hospital State ethnicity

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 or 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.

** 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 8

Signature**: Date: / /

Name: *(in block capitals)*

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. 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"

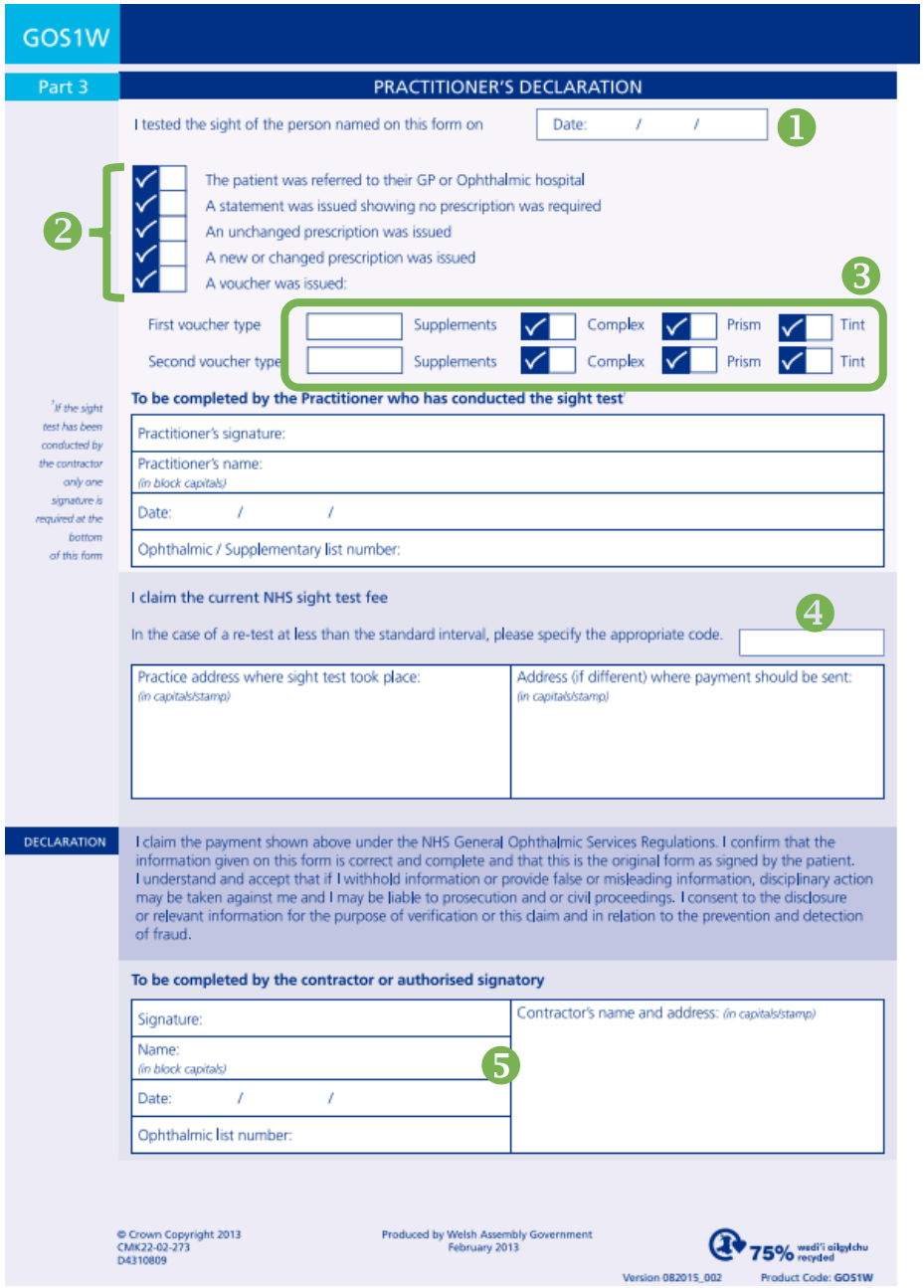
5. If the patient is receiving Universal Credit and meet the criteria (Help with health costs for people getting Universal Credit - NHS (www.nhs.uk)), please annotate the form to indicate this

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 uniocular, 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. 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



GOS1W

Part 3 PRACTITIONER'S DECLARATION

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

In the case of a re-test at less than the standard interval, please specify the appropriate code. 4

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

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:	Contractor's name and address: *(in capitals/stamp)*
Name: *(in block capitals)* 5	
Date: / /	
Ophthalmic list number:	

Produced by Welsh Assembly Government
February 2013

75% wedi'i ailgylchu recycled

Version 082015_002 Product Code: GOS1W

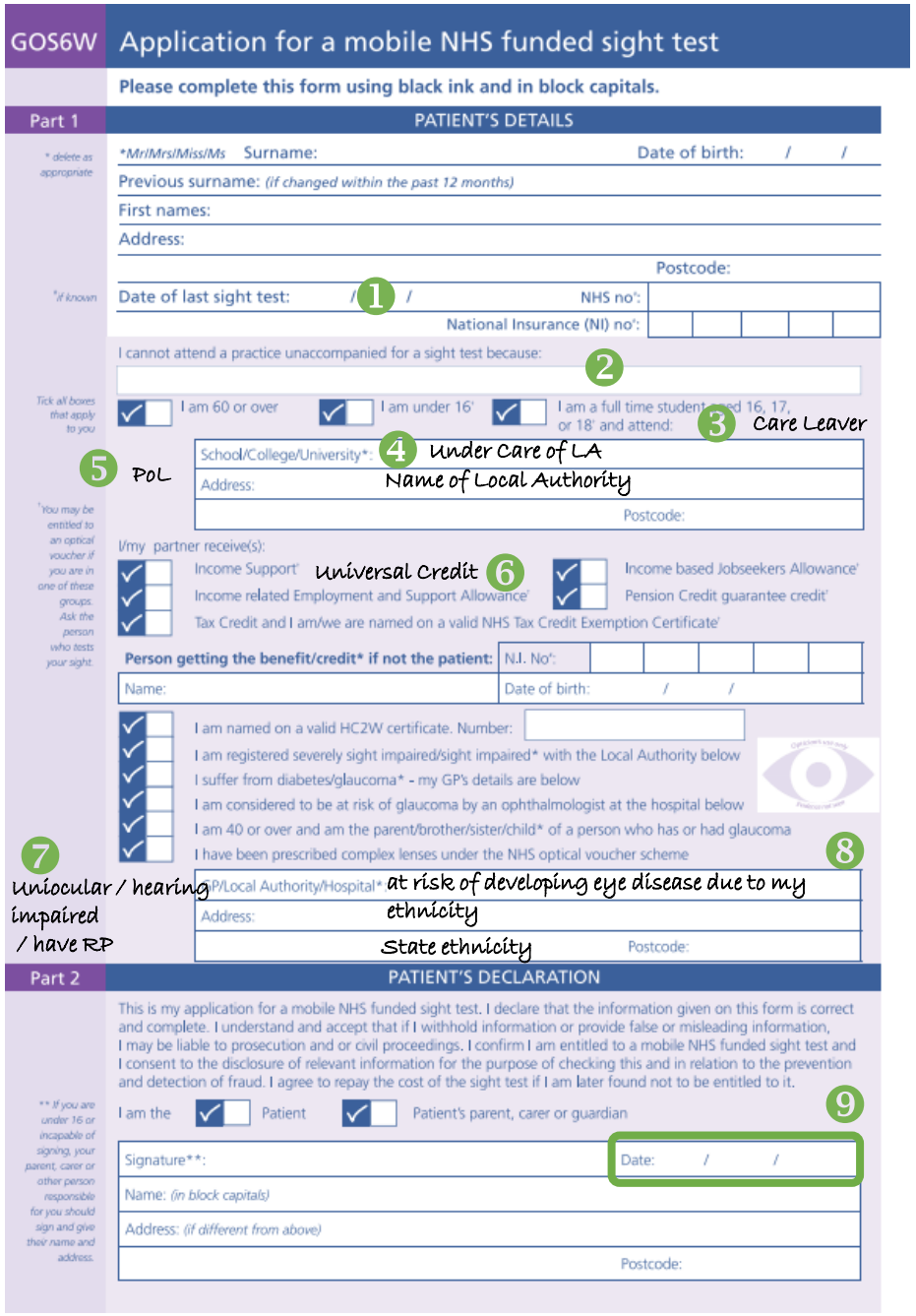
1. This date should correspond to the date at which the eye examination was completed
   NOTE: This may differ to the date in part 2 of the form e.g. when a patient has to return as the test had to stop due to a fire alarm or patient became unwell during the eye examination.
2. The Optom / OMP should 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:

*You may be entitled to an optical voucher if you are in one of these groups. Ask the person who tests your sight.

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.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

7 Uniocular / hearing impaired / have RP

8

GP/Local Authority/Hospital* at risk of developing eye disease due to my ethnicity

Address:

State ethnicity Postcode:

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

9

Signature**: Date: / /

Name: (in block capitals)

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"

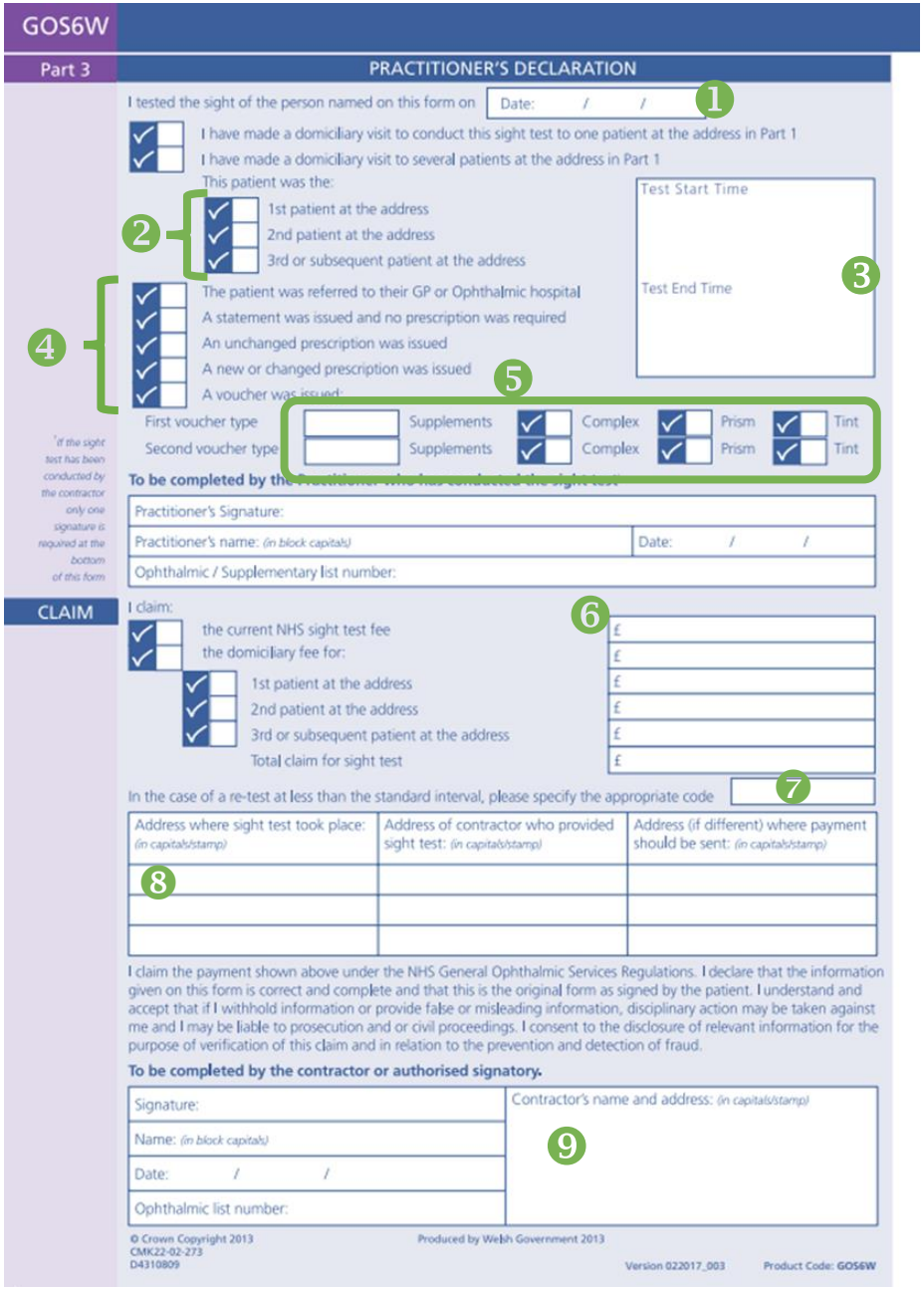
6. If the patient is receiving Universal Credit and meet the criteria (Help with health costs for people getting Universal Credit - NHS (www.nhs.uk)), please annotate the form to indicate this

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 uniocular, 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. 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



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)

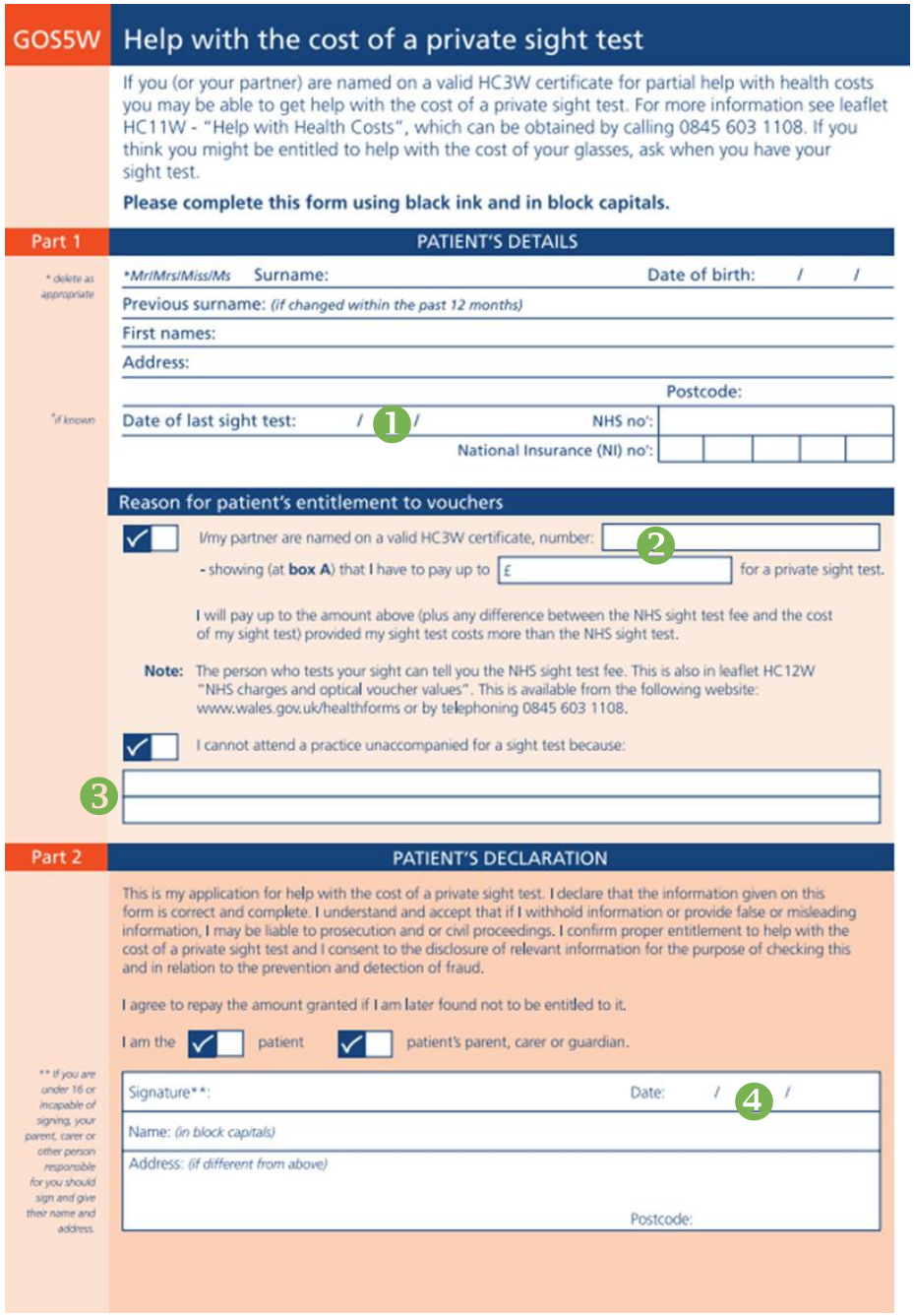
9. This section must only be completed by the Contractor or an individual who is known by NWSSP to be authorised to do so. Authorised Signatory Form July 2020.docx (live.com)

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

☑ I/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.

** 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.

Signature**: Date: / / 4

Name: *(in block capitals)*

Address: *(if different from above)*

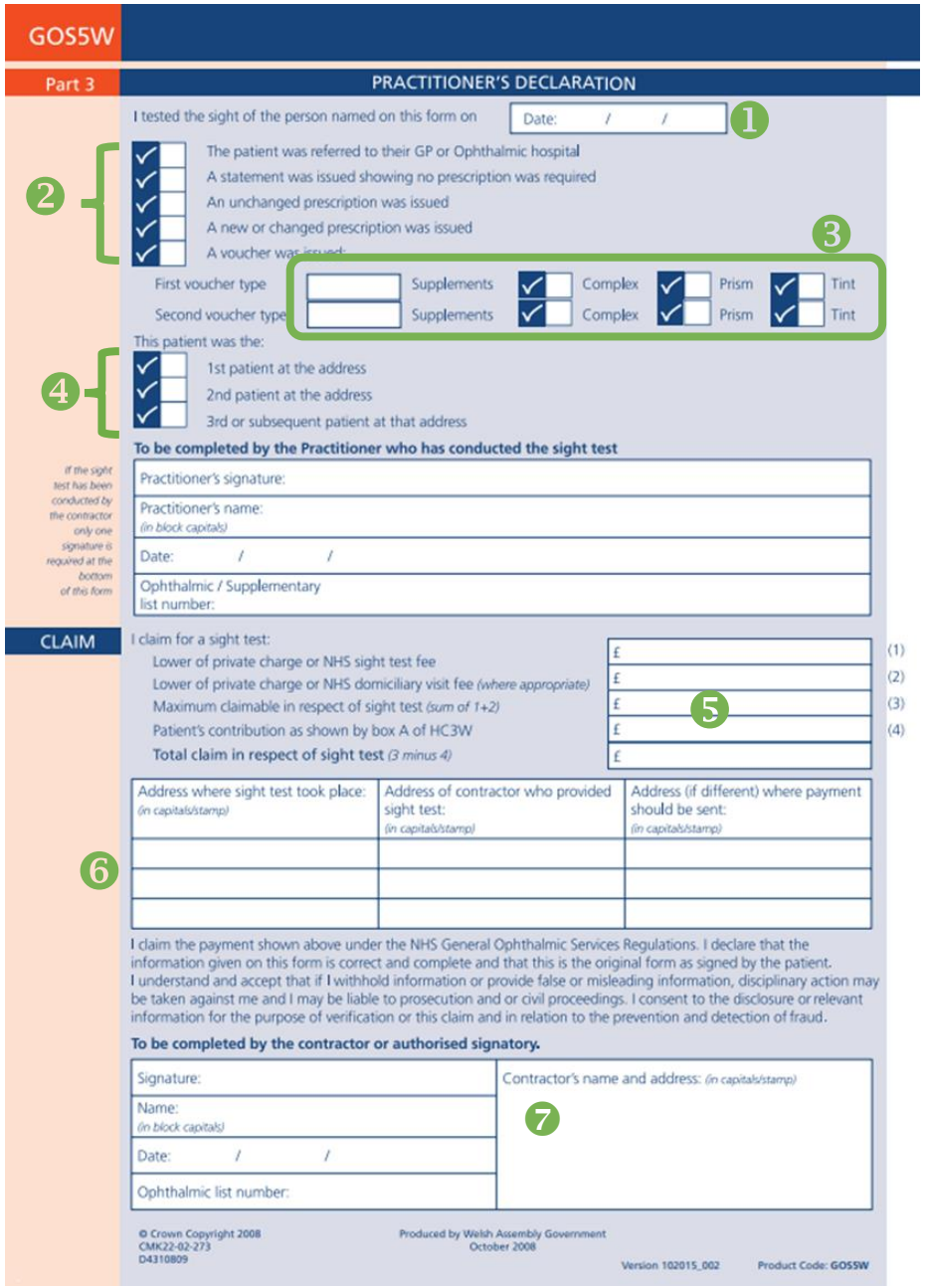
Postcode:

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. 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



GOS5W

Part 3 — PRACTITIONER'S DECLARATION

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

		Supplements	Complex	Prism	Tint
First voucher type		☐	☑	☑	☑
Second voucher type		☐	☑	☑	☑

This patient was the:

4
- ☑ 1st patient at the address
- ☑ 2nd patient at the address
- ☑ 3rd or subsequent patient at that address

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

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

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

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

6

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)*

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:	Contractor's name and address: *(in capitals/stamp)*
Name: *(in block capitals)*	7
Date: / /	
Ophthalmic list number:	

Produced by Welsh Assembly Government
October 2008
Version 102015_002 Product Code: GOS5W

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

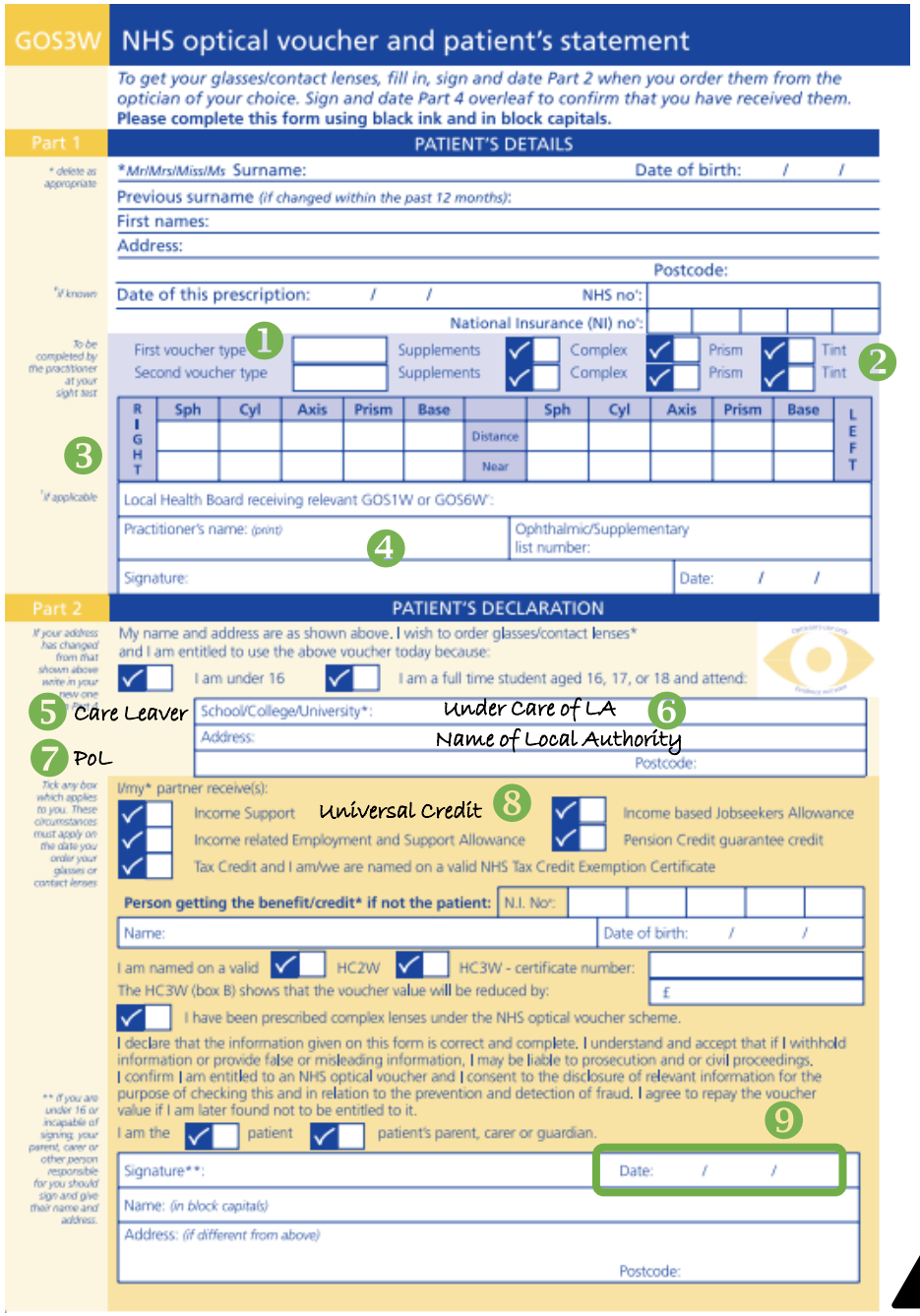
4 If the eye examination took place outside of a NWSSP approved practice, in order to be paid the correct fee, please complete this section

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 HC5W form, the Optom / OMP must ensure that an eye examination is clinically necessary

GOS3W: To be used 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:

*if known

Date of this prescription: / / NHS no*:

National Insurance (NI) no*:

To be completed by the practitioner at your sight test

First voucher type 1 Supplements Complex Prism Tint 2

Second voucher type Supplements Complex Prism Tint

3

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

*if applicable

Local Health Board receiving relevant GOS1W or GOS6W*:

Practitioner's name: *(print)* 4 Ophthalmic/Supplementary list number:

Signature: Date: / /

Part 2 PATIENT'S DECLARATION

If your address has changed from that shown above write 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

I/my* partner receive(s):

Income Support Universal Credit 8 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 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.

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

** 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.

Signature**: Date: / /

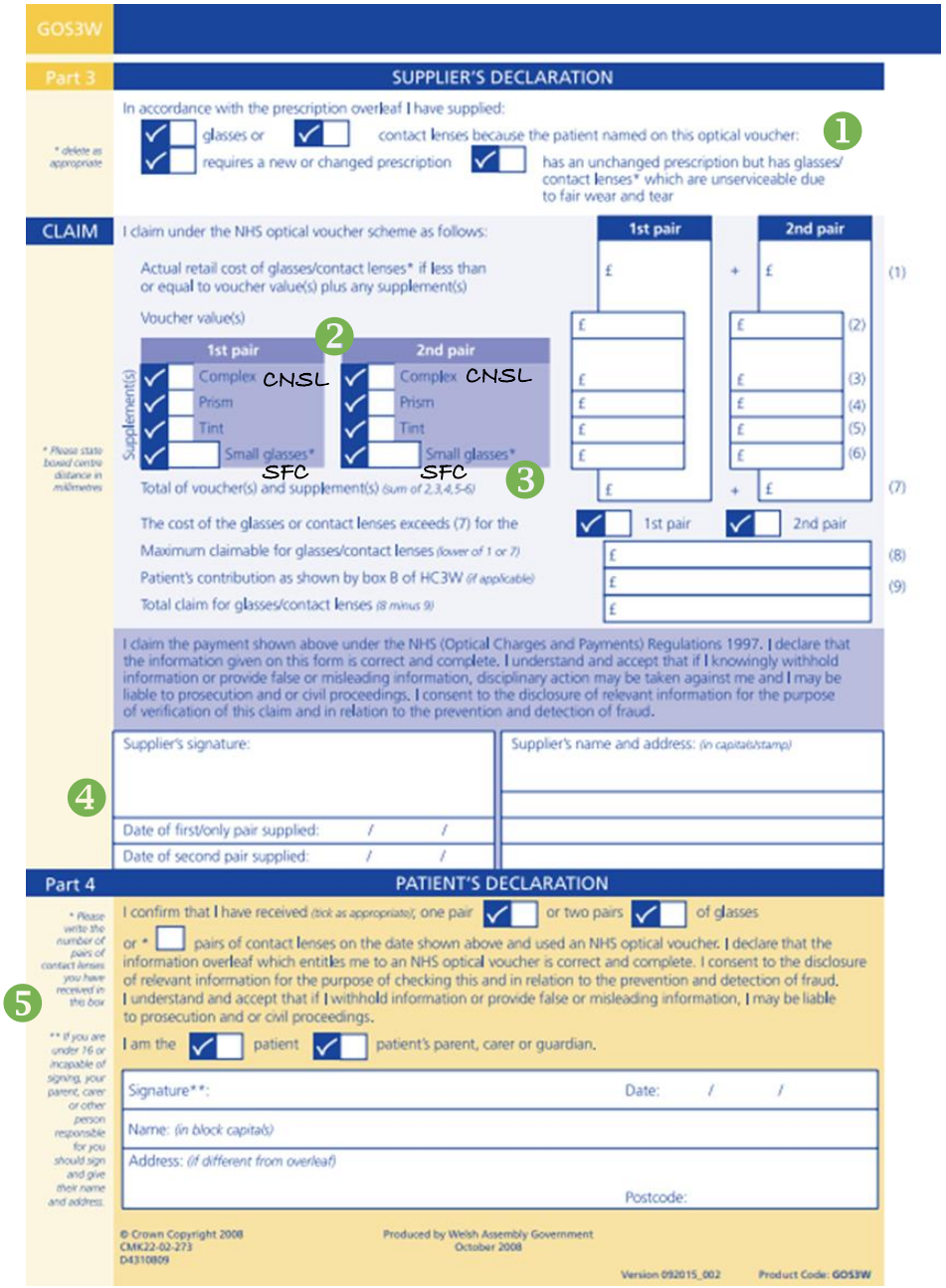
Name: *(in block capitals)*

Address: *(if different from above)*

Postcode:

1. If a GOS 3W 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 GOS 3W or HES 3 form should be annotated with the words 'BVD change' in the margin. If the change requires a higher voucher band, the GOS 3W 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 GOS 3W 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

Please note, to be eligible the patient must fall into one of the categories listed in Part B of the GOd3W 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


GOS3W

Part 3 SUPPLIER'S DECLARATION

In accordance with the prescription overleaf I have supplied:

* delete as appropriate

☑ glasses or ☑ contact lenses because the patient named on this optical voucher: 1

☑ requires a new or changed prescription ☑ has an unchanged prescription but has glasses/ contact lenses* which are unserviceable due to fair wear and tear

CLAIM

I claim under the NHS optical voucher scheme as follows:

	1st pair	2nd pair	
Actual retail cost of glasses/contact lenses* if less than or equal to voucher value(s) plus any supplement(s)	£	+ £	(1)
Voucher value(s)	£	£	(2)
Supplement(s)			
☑ Complex CNSL 2	£	£	(3)
☑ Prism	£	£	(4)
☑ Tint	£	£	(5)
☑ Small glasses* SFC 3	£	£	(6)
Total of voucher(s) and supplement(s) (sum of 2,3,4,5-6)	£	+ £	(7)

* Please state boxed centre distance in millimetres

The cost of the glasses or contact lenses exceeds (7) for the ☑ 1st pair ☑ 2nd pair

Maximum claimable for glasses/contact lenses (lower of 1 or 7)	£	(8)
Patient's contribution as shown by box B of HC3W (if applicable)	£	(9)
Total claim for glasses/contact lenses (8 minus 9)	£	

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. I understand and accept that if I knowingly 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 signature:	Supplier's name and address: (in capitals/stamp)
4	
Date of first/only pair supplied: / /	
Date of second pair supplied: / /	

Part 4 PATIENT'S DECLARATION

* Please write the number of pairs of contact lenses you have received in this box

I confirm that I have received (tick as appropriate), one pair ☑ or two pairs ☑ of glasses

or * ☐ pairs of contact lenses on the date shown above and used an NHS optical voucher. I declare that the information overleaf which entitles me to an NHS optical voucher is correct and complete. 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 understand and accept that if I withhold information or provide false or misleading information, I may be liable to prosecution and or civil proceedings.

5

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

** 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.

Signature**: Date: / /

Name: (in block capitals)

Address: (if different from overleaf)

Postcode:

CMK22-02-273
D4310809
Produced by Welsh Assembly Government
October 2008
Version 092015_002 Product Code: GOS3W

1. Please indicate the reason why the patient is receiving an NHS funded pair of spectacles. This must reflect what is written on the patient's clinical record

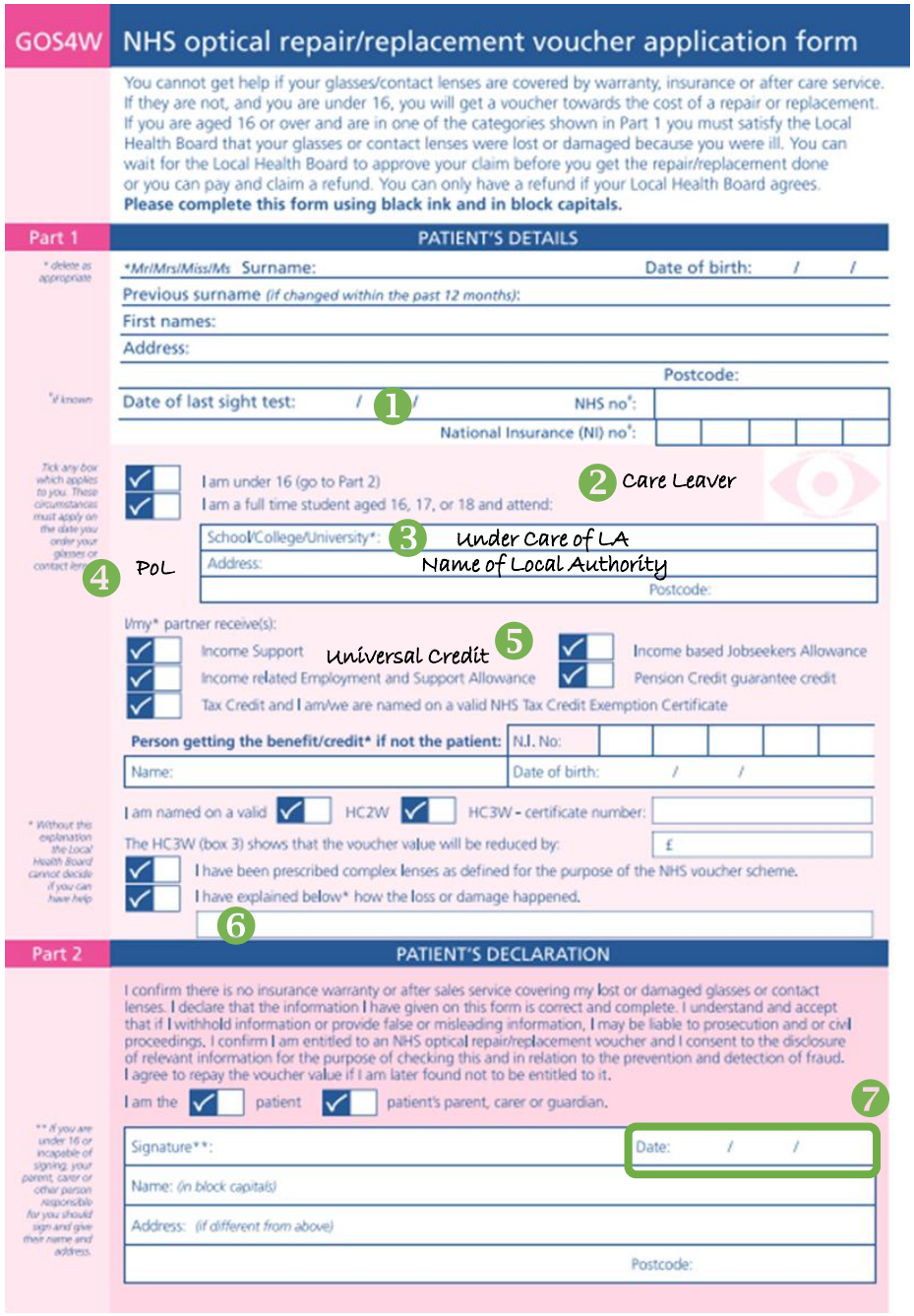
2. If a 'Child Non-Stock Lens Supplement' is being claimed, please cross out the word 'Complex' and replace with 'CNSL'
   NOTE: The supplement can only be claimed if there is evidence to demonstrate that the patient has received a lens that improves the cosmetic appearance e.g., surfaced lenses, smaller blank sizes, higher index lenses etc.)

3. 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.

4. This is the date at which the spectacles are collected

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)

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

*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 lens

I am under 16 (go to Part 2)
I am a full time student aged 16, 17, or 18 and attend: 2 Care Leaver
School/College/University*: 3 Under Care of LA
Address: Name of Local Authority
Postcode:
4 PoL

I/my* partner receive(s):
Income Support Universal Credit 5
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

* Without this explanation the Local Health Board cannot decide if you can have help

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.

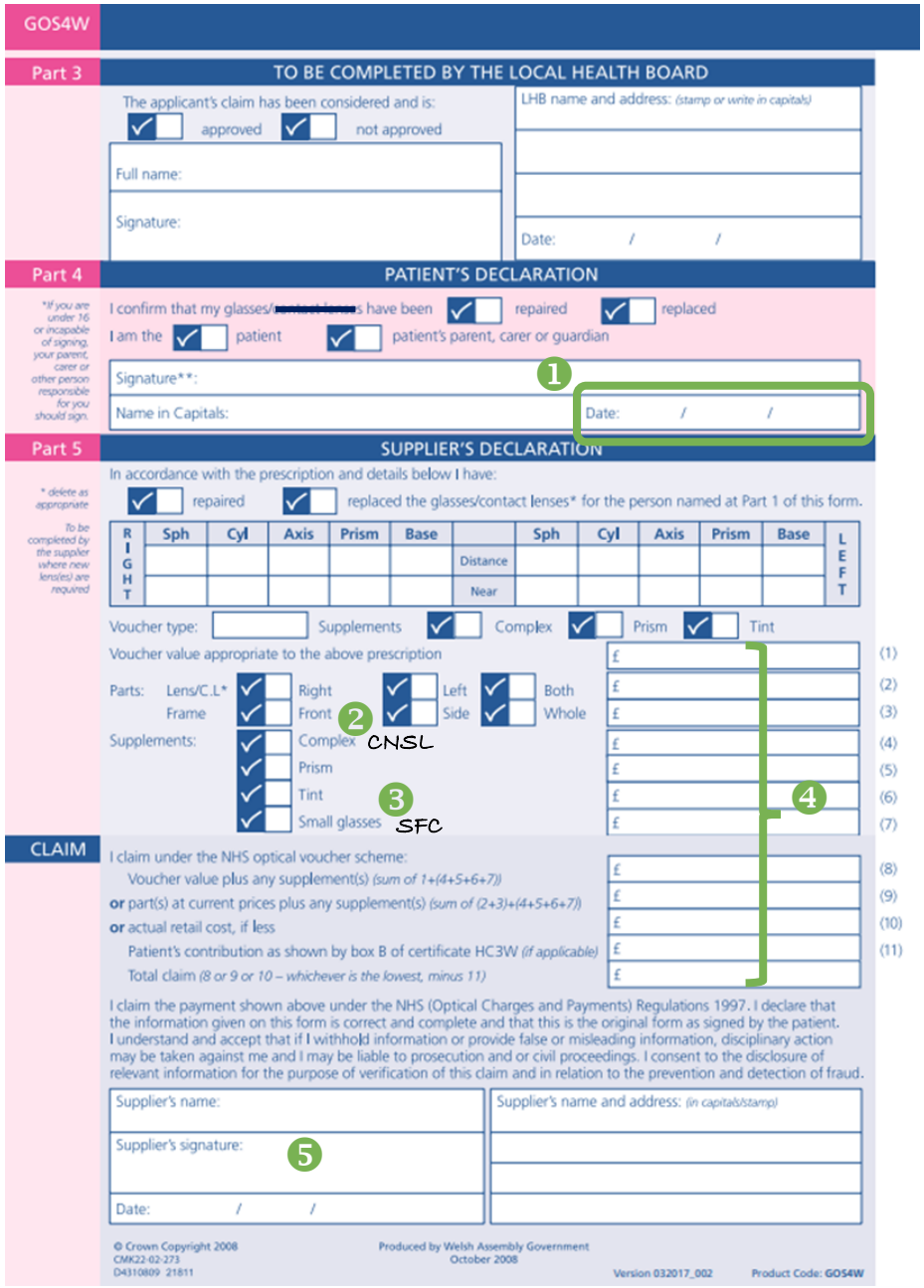
I am the patient patient's parent, carer or guardian. 7

** 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.

Signature**: 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

Please note, Patients 18 and over who are not in education 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 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

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

Full name:

Signature:

Date: / /

Part 4 PATIENT'S DECLARATION

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

I confirm that my glasses/[redacted] have been ☑ repaired ☑ replaced

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

Signature**:

Name in Capitals:

Date: / /

Part 5 SUPPLIER'S DECLARATION

* delete as appropriate

To be completed by the supplier where new lens(es) are required

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.

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

Voucher type: Supplements ☑ Complex ☑ Prism ☑ Tint

Voucher value appropriate to the above prescription £ (1)

Parts: Lens/C.L* ☑ Right ☑ Left ☑ Both £ (2)

Frame ☑ Front ☑ Side ☑ Whole £ (3)

Supplements: ☑ Complex CNSL £ (4)

☑ Prism £ (5)

☑ Tint £ (6)

☑ Small glasses SFC £ (7)

CLAIM

I claim under the NHS optical voucher scheme:

Voucher value plus any supplement(s) (sum of 1+(4+5+6+7)) £ (8)

or part(s) at current prices plus any supplement(s) (sum of (2+3)+(4+5+6+7)) £ (9)

or actual retail cost, if less £ (10)

Patient's contribution as shown by box B of certificate HC3W (if applicable) £ (11)

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 name and address: (in capitals/stamp)

Supplier's signature:

Date: / /

CMK22-02-273
D4310809 21811
Produced by Welsh Assembly Government
October 2008
Version 032017_002
Product Code: GOS4W

1. This is the date at which the patient has collected the spectacles that have been repaired / replaced

2. 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.)

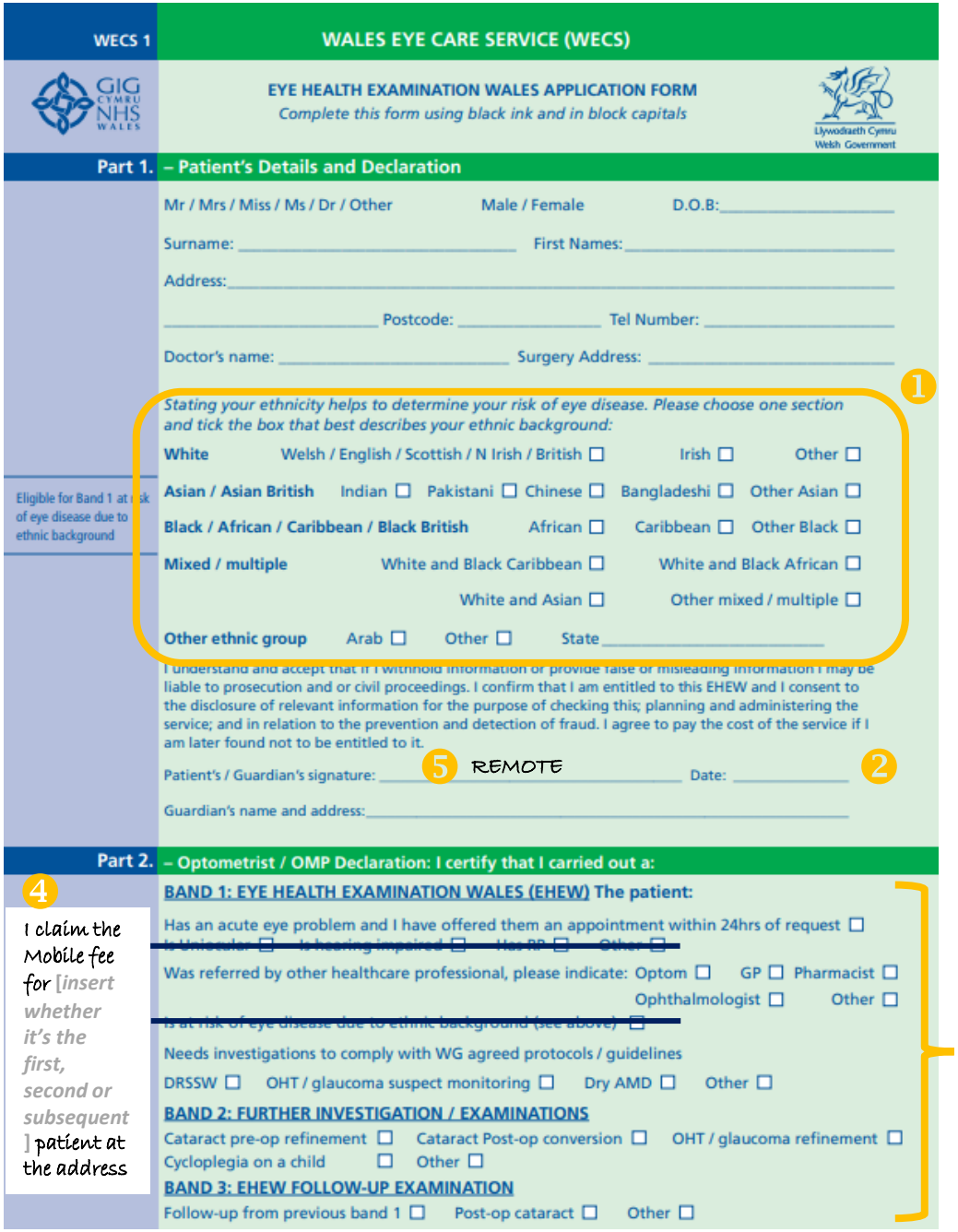
3. If a Special Facial Characteristics Supplement is being claimed, please cross out the words 'Small glasses' and replace with 'SFC'
   NOTE: The records must evident why this supplement is being claimed as well as demonstrating that a special spectacle frame has been manufactured specifically for the patient.

4. The Optom / OMP should tick all boxes that are relevant to the outcome of the eye examination

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)

⚠ A GOS 4W 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)

GIG CYMRU NHS WALES

EYE HEALTH EXAMINATION WALES APPLICATION FORM

Complete this form using black ink and in block capitals

Llywodraeth Cymru Welsh Government

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:

Eligible for Band 1 at risk of eye disease due to 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 _____

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 Date: _____ 2

Guardian's name and address: _____

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

4

I claim the Mobile fee for [*insert whether it's the first, second or subsequent*] patient at the address

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 Unicular ☐ 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 ☐

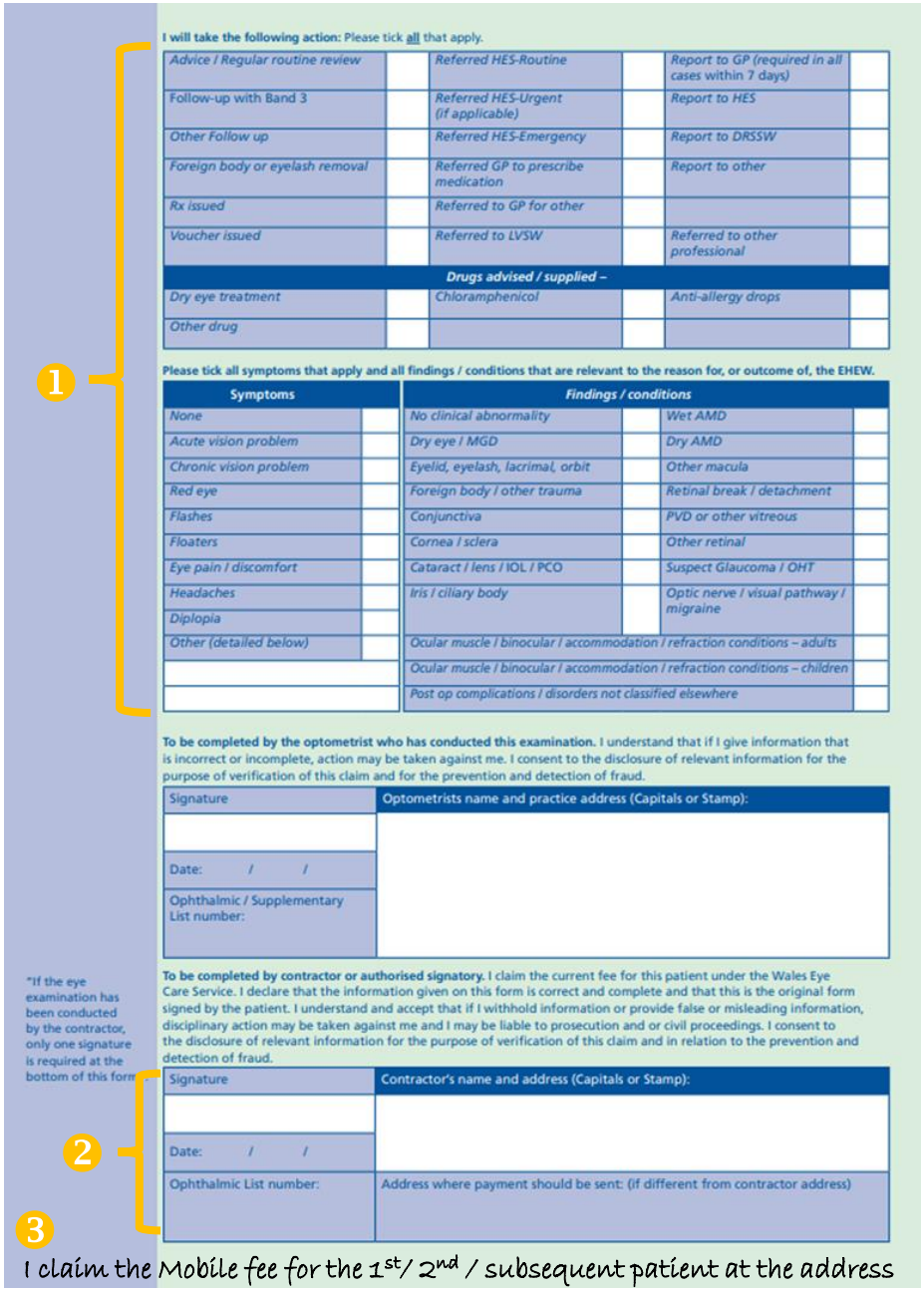
BAND 3: EHEW FOLLOW-UP EXAMINATION

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

3

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

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		*No clinical abnormality*		*Wet AMD*	
Acute vision problem		*Dry eye / MGD*		*Dry AMD*	
Chronic vision problem		*Eyelid, eyelash, lacrimal, orbit*		*Other macula*	
Red eye		*Foreign body / other trauma*		*Retinal break / detachment*	
Flashes		*Conjunctiva*		*PVD or other vitreous*	
Floaters		*Cornea / sclera*		*Other retinal*	
Eye pain / discomfort		*Cataract / lens / IOL / PCO*		*Suspect Glaucoma / OHT*	
Headaches		*Iris / ciliary body*		*Optic nerve / visual pathway / migraine*	
Diplopia					
Other (detailed below)		*Ocular muscle / binocular / accommodation / refraction conditions – adults*			
		Ocular muscle / binocular / accommodation / refraction conditions – children			
		Post op complications / disorders not classified elsewhere			

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:	

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

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)

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

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"

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