# GOS(S) 1 Application for NHS Sight Test

**Enter Surname in BLOCK LETTERS**

**Enter Forename in BLOCK LETTERS**

**Enter only if patient has changed name since last visit**

**Enter Address & Postcode in BLOCK LETTERS**

**GOS(S) 1** — **Application for NHS sight test** (PLEASE USE BLACK INK) — 9/00

*Fill in Part 1 and sign and date Part 2A. Once you have received your prescription/statement, you will be asked to sign and date Part 2B to confirm this. If the patient is under 16 years or incapable of signing, their parent, carer or other person in charge of them must sign.*

## Part 1 — PATIENT'S DETAILS

*Give details we ask for and cross the box which applies to you*

- SURNAME
- FORENAME
- PREVIOUS SURNAME
- ADDRESS
- POSTCODE

- D.O.B.
- SEX
- PATIENT IDENTIFIER
- DATE OF LAST NHS SIGHT TEST

**Enter date of birth**

**Enter "M" or "F" in appropriate box**

**leave blank**

**Enter date of last NHS sight test**

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

**Patient to enter X in appropriate box to indicate entitlement**

[ ] The patient is under 16 †     [ ] I am aged 60 or over

[ ] I am a full time student aged 16, 17 or 18 and attend: †

Name of School/College/University

Address

POSTCODE

**Patient to enter name, address postcode of school, etc**

I / my partner receive(s):

[ ] Income Support †       [ ] Working Families' Tax Credit †

[ ] Income-based Jobseeker's Allowance †   [ ] Disabled Person's Tax Credit †

} Full credit or credit reduced by £70 or less

Name of person getting the benefit/Credit if not the patient:

D.O.B.

**Patient to enter name & date of birth of person getting benefit**

[ ] I/my partner have an HC2 certificate † No

[ ] I am registered blind/partially sighted with the Local Authority named below

[ ] I suffer from:   [ ] diabetes - my GP's details are below   [ ] glaucoma - my GP's details are below

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

[ ] I am 40 or over and am the parent/brother/sister/child* of a person with glaucoma

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

**Patient to enter HC2 number**

GP/Local Authority/Hospital*

Address:

POSTCODE

**Patient to enter GP/local authority/ hospital name, address & postcode**

*delete as appropriate*

**Patient to enter X where appropriate**

[ ] I have had a sight test at the place where I normally reside because I cannot leave there unaccompanied

Evidence not produced [ ]

**Leave blank**

## Part 2 — PATIENT'S DECLARATION

**A** This is my application for an NHS sight test. I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to an NHS sight test and for the purposes of checking this, I consent to the disclosure of relevant information, including to and by the Benefits Agency, Inland Revenue and Local Authorities. I will pay the cost of the sight test if I am later found not to be entitled. In addition, a statutory penalty may be payable. I will attend the Optometric Reference Service if required.

**Patient/ parent/ Guardian/ carer to enter X in appropriate box**

[ ] I am the patient    [ ] I am the patient's parent, guardian or carer

Signature:          Date:

Name (if not the patient)

Address (if different to above)

POSTCODE

**Patient to sign & date before sight test**

**Parent/carer/ guardian to enter name**

**Parent/carer/ guardian to enter address & postcode**

**B** I confirm that I have received a prescription/statement. *Please sign here once you have had your sight test.*

Signature:          Date:

**Patient to sign & date after sight test**

# GOS(S) 1 Application for NHS Sight Test

GOS(S)1R        **PRACTITIONER'S DECLARATION**

## Part 3 +

Enter X →

I have tested the sight of the person named on this form on (*date*)    `D D – M M – Y Y Y Y` ← Enter date of sight test

Where a domiciliary visit is undertaken enter X in appropriate box →

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    2nd    3rd or subsequent patient at that address

This patient was unable to attend the practice for his/her sight test because:

Reason ← Enter reason for domiciliary visit

## Part 4

Enter X in appropriate box(es) →

The patient was referred to their GP

Statement issued

No change in prescription

A new or changed prescription was issued

Enter voucher type in appropriate box(es) →

A voucher was issued: Type `D` `N`   Supplements: `D` `N` *Complex* `D` `N` *Prism* `D` `N` *Tint* ← Enter X in appropriate box(es) to show if supplement(s) prescribed

I claim:

| | £ | P |
|---|---|---|

Enter X in appropriate box(es) to show what claiming →

the NHS sight test fee

the domiciliary visiting fee for:

1st    2nd    3rd or subsequent patient at this address    + ← Enter separate elements of claim

Total of claim for sight test    £ `   ` – `  ` ← Enter total of claim

**Note**

In the case of a re-test within two years of the previous test the appropriate reason code(s) must be entered. The CSA will refuse to pay a claim if no code or reason is given.

Enter reason code or reason for re-test within 2 years of previous test →

Reason Code `X` · `X` · `X`    Remarks

Reason Code `X` · `X` · `X`

Address where sight test took place if not the practice or the address at part 1 ← Enter address where slight test task place if not the practice or place where the patient resides

Postcode

I declare that the information I have given on this form is correct and complete and I understand that if it is not action may be taken against me. I claim payment of fees due to me for work carried out under the General Ophthalmic Service.

*Practitioner's stamp*

Sign, date, enter list number, payment, location code and stamp →

Practitioner's signature:

Date: `D D – M M – Y Y Y Y`

Ophthalmic list number:

Payment location code:

+    +

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