

GLAUCOMA REFERRAL REFINEMENT CLAIM FORM

Patient's details

First name	Surname	Previous surname (if changed within past 12 months)	Date of birth	Postcode

Bexley GP name	Surgery address

Consultation outcome

Reason for repeat			Abnormality on repeat?		Referred?	
IOP readings NCT/Appl	Field alone	IOP and Fields	Appl IOP	Fields	Yes	No
R L			R L	Yes / No		

<p>I confirm I have conducted the repeat tests in accordance with the protocol. I understand that the Care Trust will monitor all referrals and may from time to time ask to see the records of patients examined under the scheme.</p> <p>Optometrist's signature</p> <hr/> <p>Print name</p>	Practice stamp
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Patient's declaration and consent

<p>I confirm I have had the inside of my eyes examined, a repeat fields test by the optometrist and/or the pressure test with drops (<i>delete as appropriate</i>).</p> <p>I consent to the results of these tests being collected for the purpose of audit and ensuring best practice amongst optometrists.</p>		
<table border="1"> <tr> <td>Patient's Signature</td> <td>Date</td> </tr> </table>	Patient's Signature	Date
Patient's Signature	Date	

Fee Claimed (please circle)	IOP £10	VF £14	Both £20
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Please send completed forms with summary form to:

Revised Feb 06	Christine Pearson, Kent Primary Care Agency, 11 Station Road, Maidstone, ME14 1QH
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