# Application for non-tolerance voucher

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Details** | | | | | | | |  | **Practice Address** | | | | | | |
| **Title: Mr, Mrs, Mast, Miss, Ms** | | | | | | | |  |
| **Surname** | | | | | | | |  |  | | | | | | |
| **Other Name(s)** | | | | | | | |  |  | | | | | | |
| **Address** | | | | | | | |  | **Telephone** | | | | | | |
|  | | | | | | | |  | **Email address**  **(nhs.net only)** | | | | | | |
|  | | | | | | | |  | **Fax Contact Name** | | | | | | |
| **Post Code** | | | | | | | |  | **Contact Name** | | | | | | |
| **D.O.B.** | | | | | | | |  | **Role** | | | | | | |
| **Date of Application** | | | | | | | | | | | | | | | |
| **Reason for Non Tolerance** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Lens Type** | | | **Initial voucher type** | | **Date of supply** | | | | | | **Length of wear** | | | | |
| **Action Proposed** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | **OCs Dist/Near** |
|  | | | | | | | | | | | | | | | |  |  |
| **Original Prescription** | | | **Exam Date** | | | **OCs Dist/Near** | | | | | | **BVD** | | |
|  | **Vision** | **SPH** | **CYL** | **AXIS** | | | **PRISM** | | | **BASE** | | | **VA** | **ADD** | |
| **RE** |  |  |  |  | | |  | | |  | | |  |  | |
| **LE** |  |  |  |  | | |  | | |  | | |  |  | |
| **Retest Prescription** | | | **Exam Date** | | | **OCs Dist/Near** | | | | | | **BVD** | | |
| **RE** | **Vision** | **SPH** | **CYL** | **AXIS** | | | **PRISM** | | | **BASE** | | | **VA** | **ADD** | |
| **LE** |  |  |  |  | | |  | | |  | | |  |  | |
| **LE** |  |  |  |  | | |  | | |  | | |  |  | |

**Completed forms should be submitted to your NHS England Regional Local Team – [england.southeastoptometry@nhs.net](mailto:england.southeastoptometry@nhs.net) or by post to Eye Health Team, NHS England – South East, 18-20 Massetts Road, Horley, Surrey RH6 7DE. You must retain this form with the patient’s records once it has been returned to you with a decision and only submit a GOS3 to PCSE if the application has been approved.**

For internal Use: Request approved / not approved

Date: Signature: Name (print):