**Repeat measures & Monitoring (OHT & glaucoma suspects)**

**Referral and Payment Claim Form**

**PAYMENT PROCESS -** Claims will be processed monthly and one payment will be issued.

**REFERRAL -** use this form for referral if hospital eye service is required.

**NOTE TO GP -** there is no requirement to take action with this other than refer via Choose & Book, adding any relevant medical information as per normal process.

**Please ensure this form accompanies referral**

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| **For Finance Purposes** Unique Practice GDPR Identifier:  (Format = ODS code + 10 digit practice patient I.D) | |  | | | | |
| Surname: | | |  | Other names: | | Date of Birth: |
|  | Address: | | | | | |
| Postcode: | |  | | | Telephone Numbers: | |
| GP Name: | |  | | | GP Practice: | |

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|  | | **PHASE 1 – REPEAT MEASURES** | | | | | | | | | | | | | | | | | | |
|  | | **THIS PATHWAY IS ONLY FOR PATIENTS REGISTERED WITH registered with a GP Practice in the city of Bristol within the boundaries of BNSSG CCG WITH NORMAL OPTIC DISCS.** If there is referable optic nerve head damage or the patient is registered with a GP from another CCG area please refer to hospital eye services via letter or GOS18 as usual. **OPTOMETRISTS MUST BE ACCREDITED TO PARTICIPATE IN THIS SCHEME.** | | | | | | | | | | | | | | | | | | |
| **IOP** | | | | |  | | Measured in mmHg | | | | | | | | | | | | | |
|  | | | | | **Date** | | **Time** | | **Instrument** | | | | | **Put an ‘X’ to confirm** | | **RE** | | **LE** | |
| **Original (from sight test)** | | | | |  | |  | | ***Specify****:* | | | | |  | |  | |  | |
| **1st Repeat** *only with Goldmann - if IOP at sight test ≥24mmHg* | | | | |  | |  | | **Goldmann** I confirm tonometer has been calibrated according to manufacturer’s instructions | | | | |  | |  | |  | |
| **2nd Repeat** *only with Goldmann if IOP ≥24mmHg* | | | | |  | |  | | **Goldmann**  I confirm tonometer has been calibrated according to manufacturer’s instructions | | | | |  | |  | |  | |
|  | | **Do not refer for IOP alone unless at least one eye is** *≥***24mmHg or above on BOTH occasions** | | | | | | | | | | | | | | | | | | |
|  | | **Visual Fields** | | | | | | | | | | | | | | | | | | |
|  | | | **Date** | **Time** | | | | **Instrument** | | |  | **RE** | | | | | **LE** | | |
| **Original**  *from Sight test* | | |  |  | | | |  | | |  | **Normal** | | |  | | **Normal** | |  |
|  | **Visual field defect consistent with glaucoma** | | |  | | **Visual field defect consistent with glaucoma** | |  |
| **Repeat**  *on different date* | | |  |  | | | |  | | |  | **Normal** | | |  | | **Normal** | |  |
|  | **Inconsistent defect** | | |  | | **Inconsistent defect** | |  |
|  | **Consistent defect** | | |  | | **Consistent defect** | |  |
|  | **Do not refer for Visual Field defect alone unless there is a repeatable visual field defect consistent with glaucoma in the same area of the plot on BOTH occasions. Put an ‘X’ outcome option** | | | | | | | | | | | | | | | | | | | |
| **Patient does not need referral** | | | |  | | **Patient needs referral** | | | |  | | | ***If referral required, please fill in the following details*** | | | | | |

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|  | **Referral**  **Prescription Details** | | | | | | | | | | | | | | |
|  | | **Vision** | **Sph** | | **Cyl** | **Axis** | | **Prism** | **Base** |  | **VA** | | **Add** | **Near VA** |
| **RE** | |  |  | |  |  | |  |  |  |  | |  |  |
| **LE** | |  |  | |  |  | |  |  |  |  | |  |  |
| **Please record CD ratios here** | | | | **RE** | | |  | | **LE** |  |  | | | |
|  | **Other Information** | | | | | | | | | | | | | | |
|  | **PHASE 2 - MONITORING** | | | | | | | | | | | | | | |
|  | **THIS PATHWAY IS ONLY FOR PATIENTS REGISTERED WITH A GP PRACTIVE WITHIN THE CITY OF BRISTOL WHO HAVE OCULAR HYPERTENSION OR SUSPECT GLAUCOMA AND WHO HAVE BEEN ISSUED WITH A MANAGEMENT PLAN FROM THE HES. OPTOMETRISTS MUST BE ACCREDITED TO PARTICIPATE IN THIS SCHEME.** | | | | | | | | | | | | | | |
|  | **OUTCOME** | | | | | | | | | | | **Put an ‘X’ outcome option** | | | |
|  | **No change in clinical status. Next appointment as per protocol.** | | | | | | | | | | |  | | | |
|  | **Change in clinical status. Patient referred back to HES** | | | | | | | | | | |  | | | |

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|  | **FEES** | | |
| **PHASE 1a (part 1)**  Repeat IOP with Goldmann  £12.50 | |  | Practice stamp/address |
| **PHASE 1a (part 2)**  Repeat IOP on separate occasion with Goldmann Applanation Tonometer  £22.50 | |  |
| **PHASE 1b**  Repeat visual fields on separate occasion  £25.00 | |  | I confirm I have conducted the above tests in accordance with the protocol. I understand that the Clinical Commissioning Group (CCG) will monitor all referrals and may from time to time ask to see the records of patients examined under the scheme. **Optometrist’s Signature:**  Print name |
| **PHASE 1c** (**patients from a non-accredited PRACTICE seen at the request of the CCG)**  Goldmann applanation tonometry, visual fields, dilated examination of the disc and Van Herick’s test  £50.00 | |  |
| **PHASE 2**  OHT / Glaucoma Suspect Monitoring  £50.00 | |  | **FEE CLAIMED**  **£** |

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| **Patient’s declaration and consent** | |
| **I confirm I have undergone repeat pressure and/or field measures OR, had a monitoring appointment as per my HES issued management plan.**  **I consent to the results of these tests being collected for the purpose of audit and ensuring best practice amongst optometrists.** | |
| **Patient’s signature Date** | |
| **PATIENT OUTCOME Put an ‘X’ outcome option** | |
| **Patient does not need referral**  **Post this form to BNSSG CCG:** BNSSG CCG Finance Team, South Plaza, Marlborough Street, Bristol BS1 3NX  **or email to: (only from an NHS.net account)**  [bnssg.ceff.nca@nhs.net](mailto:bnssg.ceff.nca@nhs.net) | **Patient needs referral**  **Post this form to BNSSG CCG:** BNSSG CCG Finance Team, South Plaza, Marlborough Street, Bristol BS1 3NX  **or email to: (only from an NHS.net account)**  [bnssg.ceff.nca@nhs.net](mailto:bnssg.ceff.nca@nhs.net)  **ALSO** Post/fax this form to patient’s GP with standard covering letter (supplied) |