# Application for non-tolerance voucher

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| **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. 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):