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			

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):