NI PEARS ASSESSMENT OUTCOME & CLAIM FORM

Health and Social Care Board

Patient Details	Optometric Practice Details
Name:	NI PEARS Accredited Optometrist:
DOB:	Personal Code:
Health and Care Number:	Practice Name :
Date of Last Eye Examination: GOS ☐ Private ☐	Practice Code:

Referral Source (please tick)	Self-Referral ☐ GP ☐ Pharmacy ☐ Other ☐ _____	
NI PEARS Activity (please tick)	Date of Referral: _____	First Appointment ☐ **OR** Follow up Appointment ☐ Date:_____ Date:_____
Presenting Symptom (please tick/specify)	Red eye ☐ Painful eye ☐ Visual change ☐ Flashes & Floaters ☐ Foreign Body ☐ Other (please specify): _____	
Diagnosis (please tick/specify)	Conjunctivitis ☐ Dry Eye ☐ Blepharitis ☐ Sub-conjunctival haemorrhage ☐ Chalazion/Hordeolum ☐ Episcleritis ☐ Trichiasis ☐ Simple Entropion / Ectropion ☐ Corneal Foreign Body ☐ Corneal Abrasion ☐ Keratitis ☐ Trauma ☐ PVD ☐ Iritis ☐ *(Iritis: New* ☐ *or Recurrent* ☐) Cataract ☐ Wet AMD ☐ Ocular Migraine ☐ Other (Please specify) _____	
Outcome of NI PEARS Assessment (please select all that apply)	Discharge ☐ Manage and Treat ☐ Ophthalmic Medication Recommended ☐ Refer to GP ☐ Refer Routinely to Out-Patient Ophthalmology ☐ Refer Urgently to Secondary Care ☐ Name of Hospital & Service: _____	
Patient Declaration and Signature	**a) I understand** that if I knowingly give information that is false, action may be taken against me. **b) I declare** that the information I have given is correct and complete to the best of my knowledge. **c) I confirm** I have had an Enhanced Service provided. **d) I consent** to the outcomes of the Enhanced Service provided to me being collected for the purpose of service audit. **e) I am aware** that information relating to the Enhanced Service provided to me, being made available to other Departments / Agencies for Health and Social Care planning purposes and for the purposes of preventing or detecting fraud. Signed: Date:	
Optometrist Declaration and Signature	The reason for the provision of this Enhanced Service has been explained to the patient (or guardian) who agrees to it. I declare that I have provided the Enhanced Service in line with the service specification in force at this time The patient has been made aware that information relating to the service provided may be shared with other HSC organisations." Signed: Personal Code: Date:	

PLEASE SEND THE COMPLETED FORM:
FAO ANGELA DOWDS, OPHTHALMIC SERVICES,
BUSINESS SERVICES ORGANISATION2 FRANKILIN STREET BELFAST BT2 8DQ
CLAIM FORMS MUST BE SUBMITTED WITHIN 3 MONTHS OF THE ES PROVISION
Note: a separate claim form must be submitted for a follow up appointment claim.