HSC Business Services Organisation

LESPR Form (Updated Dec18)

Enhanced Services Patient Record

[for Ophthalmic Claim System]

PART 1 – PATIENT INFORMATION

Surname											**Forename(s)**	
Health & Care No.											**Date of Birth**	

Optometry Local Enhanced Service (LES)

- Please complete this form using **block capital letters** and **black ink** only.
- The optometrist / optician or practice staff should complete Parts 1 and 2.
- The patient must read Part 3 before signing any claims on the reverse side of this page. If the patient is under the age of 16 or unable to complete the form personally for any reason, a representative should sign on their behalf.

PART 2 – PRACTICE INFORMATION					**Practice Name**	
Practice Code						

PART 3 – PATIENT DECLARATION

By signing my name against any of the claims on the reverse side of this form, I agree that:

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** that 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 have been made aware that** information relating to the Enhanced Service provided to me may be made available to other Departments / Agencies for Health and Social Care planning purposes and for the purposes of preventing or detecting fraud.

This form is to be retained in the practice as per regulations unless requested by an authorised body. Please contact BSO if this form is required in an alternative accessible format.

PART 4 – PATIENT ENHANCED SERVICE CLAIM RECORD

The optometrist / optician or practice staff must complete **sections a, b and c** below. The patient must read **Part 3 – Patient Declaration** on this form and then sign **section d**. If the patient is under the age of 16 or unable to sign the form personally, this field can be signed on their behalf by a representative who must then complete **section e**. The Optometrist who carried out the LES provided must sign **section f** and complete **section g**. This should be repeated on a separate row for each individual Local Enhanced Service provided.

a. Date	b. Claim ID	c. Please state LES provided	d. Signature of Patient (or on patient's behalf)	e. Relationship to Patient (if applicable)	f. Signature of Optometrist	g. OO / OMP Code

ES SERVICE CODES – Please use the codes listed below in bold to complete column c: "Please state LES provided":

LES LEVEL 1 IOP Referral Refinement : **LES 1** LES LEVEL 2 ENHANCED CASE FINDING: **LES 2** NIPEARS**:** First assessment **NIP A** Follow up **NIP F**

Post Operative Cataract Review **CR** Glaucoma Monitoring **GM**