

**NHS West Sussex**  
 Glaucoma Referral Refinement  
 Enhanced Service Contract

**PAYMENT REQUEST SHEET**

<b>PRACTICE</b>	Name	
	Location	
<b>CONTRACTOR</b>	Name	
<b>PERFORMER</b>	Name	
	Number	

Patient Details				Initial Reading (pmt inc in sight test fee)				Contact Reading 1 (£12.50 fee)				Contact Reading 2 (£22.50 fee)			
Name	M/F	Dob	GP Practice code	Date	Pressure		Outcome	Date	Pressure		Outcome	Date	Pressure		Outcome
					L	R			L	R			L	R	

Signature .....

Date .....

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Position .....

**Send completed forms to:**  
**The Dental and Optometry Team, 36-38 Friars Walk, Lewes, BN7 2PB**  
**Safe Fax No. 01273 403549**