# Application for second opinion A close-up of a logo  Description automatically generated with medium confidence

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| **Patient Details** |  | **Practice Address** |
| **Title: Mr, Mrs, Mast, Miss, Ms** |  |
| **Surname** |  |  |
| **Forename(s)** |  |  |
| **Address** |  |  |
|  |  |  |
|  |  | **Telephone** |
|  |  | **Fax** |
| **Post Code** |  | **Contact Name** |
| **D.O.B.** |  | **Designation** |

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| --- |
| **Date of Application** |
| **Reason for requesting second opinion** |
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| **ICB USE ONLY** |
| REQUEST AUTHORISED BY(Ophthalmic Advisor) | Name (PRINT) | Signature | Date |
| Request authorised by (ICB) | Name (PRINT) | Signature | Date |

**PLEASE RETURN FORM:**

**By secure email** to **lscicb-bl.optom@nhs.net**

Providers please note that nhs.net email should be used when emailing.

Please attach this form to the GOS1 if the application has been approved.