

Patient Experience Questionnaire

[Insert name of CCG / PEC] Integrated Glaucoma Service

You have been seen within the community integrated glaucoma service. This service allows for further investigation in optical practice to determine whether a referral to a hospital specialist is needed.

For persons already known to have glaucoma (or a related condition such as Ocular Hypertension), this service allows for their regular monitoring assessment in optical practice, delivering care closer to home.

To ensure that the service has been set up to meet your needs, we are keen to hear your views regarding your experience of the service and would therefore ask that you take a few minutes to fill in this short questionnaire.

**Optical practice name:** …………………………………………………………………..…………………………………..

**How likely would you be to recommend this service to your friends and family?**

 Extremely likely ❑ Likely ❑ Neither likely nor unlikely ❑ Unlikely ❑

 Extremely unlikely ❑ Don't know ❑

**Do you have any further comments that you would like to make?**

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**Please provide your name (If you would like a response):**

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**THANK YOU FOR TAKING THE TIME TO FILL IN THIS QUESTIONNAIRE**