RBH WET AMD RAPID ACCESS REFERRAL FORM

Once complete, please email the form to:

Rbb-tr.amd@nhs.net

Date of referral:

Royal Berkshire NHS Foundation Trust

Patient Details		
Name:	**DOB:**	
Address:		
Telephone Number:	**Hospital Number:**	(if known)
GP:	**GP Surgery:**	
Optometrist Details		
Name:	**Practice Address:**	
Telephone Number:		

Affected Eye: **Right** ☐ **Left** ☐

Best Corrected Visual Acuity: **Right** _____ **Left** _____ **(in Snellen format please)**

BCVA must be between 6/12 and 6/96 (vision better than 6/12 may be referred if it is the patient's only eye)

Duration of symptoms: _____ **Was this an incidental finding? Y / N**

Signs and Symptoms in the affected eye	**(please tick)**	**Relevant history**	
Sudden onset Visual Distortion	☐	**Cataract**	**R / L**
Recent drop in VA	☐	**Pseudophakia**	**R / L**
Central scotoma	☐	**Myopia**	**R / L**
Macular Haemorrhage	☐	**Glaucoma**	**R / L**
Fluid noted on OCT	☐	**Diabetes**	**R / L**
Macular Drusen	☐	**Amblyopia**	**R / L**
AMD in other eye	☐	**Dementia**	**Y / N**

Further Details

Please only use this referral form for suspected wet AMD and Myopic CNV. Referrals should be sent to us within 1 working day and we aim to see patients within 2 weeks of receipt of referral. As our service demand is very high, efficient referrals will aid the appropriate booking of clinics.

Thank you.

Telephone Number: 0118 322 7169 (option 5)