|  |  |  |  |
| --- | --- | --- | --- |
| **WET AGE RELATED MACULAR DEGENERATION RAPID ACCESS REFERRAL FORM** |

|  |
| --- |
| DATE |
| **<<Last Exam Date>>** |

 |
| Please Select Consultant by ticking appropriate box |

|  |  |  |  |
| --- | --- | --- | --- |
| **Leighton Hospital** |  | **FAX No:** | **01270 273463** |
| **Eyecare Medical** |  | **FAX No:** | **01625 440002** |

Macclesfield hospital no longer accepting Fax, please email.  |
| **Patient Details** |
|

|  |  |
| --- | --- |
| Patient Name: | **<<Title>>,<<First Name>>,<<Last Name>>** |
| Patient Address: | **<<Full Address>>** |

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|  |  |
| --- | --- |
| Date of Birth: | NHS Number: |
| **<<Short DOB>>** |  |
| Contact Telephone Nos: |
| **<<Home Phone>>****<<Mobile Phone>>** |

 |
| **GP Name:** | **<<GP Name>>** | Surgery**<<Surgery Name>>** |
| **Optometrist Details (Please print, do not use a stamp)** |
| Optometrist Name: | **<<Last Exam Optician>>** | GOC No: |  |
| Practice Name & Address: | **<<Branch Full Address>>** |

|  |  |
| --- | --- |
| Telephone No: | **<<Branch Telephone 1>>** |
| Fax No: | **<<Branch Fax>>** |

 |
| **AFFECTED EYE** | Right |  | Left |  |
| Past History in either eye: |
| Previous AMD | Right |  | Left |  |
| Myopia | Right |  | Left |  |
| Other | Right |  | Left |  |
| **REFERRAL GUIDELINES** |
| **Presenting Symptoms in Affected Eye (one answer must be yes)** |
| Duration of visual loss: Please specify |  |
| 1. Visual Loss | Yes |  | No |  |
| 2. Spontaneously reported distortion | Yes |  | No |  |
| 3. Onset of scotoma (or blurred spot in central vision) | Yes |  | No |  |
| **FINDINGS Best corrected VA (must be 6/96 or better in affected eye)** |
| 1. Distance VA | Right |  | Left |  |
| 2. Near VA | Right |  | Left |  |
| 3. Macular drusen (either eye) | Right |  | Left |  |
| **In affected eye ONLY, presence of:** |
| 4. Macular haemorrhage (perentinal, retinal, subretinal) | Yes |  | No |  |
| 5. Subretinal fluid | Yes |  | No |  |
| 6. Exudate | Yes |  | No |  |
| **COMMENTS** |
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