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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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>>** | | | | | |  |  | | --- | --- | | 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** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |