**Wet ARMD Referral Form**

Please note – all fields are mandatory and should be **completed electronically**. Incomplete forms will be returned and may result in delays in arranging the appointment.

|  |  |
| --- | --- |
| **Patient Details** | |
| Name: Click here to enter text. | Date of birth: Click here to enter text. |
| Address: Click here to enter text. | Phone number: Click here to enter text. |
| Post code: Click here to enter text. | NHS number (if known):Click here to enter text. |
| **GP Details:** | |
| GP Name: Click here to enter text. | GP Surgery: Click here to enter text. |
| **Optometrist Details:** | |
| Optometrist Name: Click here to enter text. | Optometrist Practice: Raison Opticians |
| Address : 26 Meneage Street, Helston, TR13 8AB | Date of examination: Click here to enter text. |

1. **Please complete the details about refraction**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **RIGHT** | | | | **LEFT** | | | |
|  | Sph | Cyl | Axis | VA | Sph | Cyl | Axis | VA |
| **Distance** | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Near** | Click here to enter text. | | | Click here to enter text. | Click here to enter text. | | | Click here to enter text. |
| **Tonometry (if performed)** | | | **RIGHT** | | | **LEFT** | | |
| AT  NCT | | | Click here to enter text. mm HG | | | Click here to enter text. mm HG | | |

1. **What is the main reason for referring this patient (please click the relevant box)?**

|  |  |  |
| --- | --- | --- |
| a) | I am highly suspicious that this patient has Wet ARMD |  |
| b) | This patient has mainly dry ARMD but I suspect they may have Wet ARMD |  |
| c) | I suspect this patient has Branch Retinal Vein Occlusion (BRVO) |  |
| d) | I suspect this patient has Central Retinal Vein Occlusion (CRVO) |  |
| e) | I suspect this patient has Diabetic Macular Oedema (DMO) |  |

1. **Which eye has been affected**

|  |  |  |
| --- | --- | --- |
| a) | Left |  |
| b) | Right |  |
| c) | Both |  |

1. **How long has the patient had symptoms for?**

|  |  |
| --- | --- |
| a) | For Click here to enter text. days or Click here to enter text. months |
| b) | Patient is not symptomatic but I found abnormality on a routine check |

1. **What symptoms does this patient have? (Please tick all that applies)**

|  |  |  |
| --- | --- | --- |
|  | **RIGHT** | **LEFT** |
| Decrease/blurred vision |  |  |
| Distortion of vision |  |  |
| Difficulty reading |  |  |
| No symptoms |  |  |
| Other |  |  |

1. **What is your clinical observation? (Please tick all that applies)**

|  |  |  |
| --- | --- | --- |
|  | **RIGHT** | **LEFT** |
| Amsler distortion |  |  |
| Macular haemorrhage |  |  |
| Macular Drusen |  |  |
| Retinal fluid in macula |  |  |
| Retinal fluid on OCT retinal scan |  |  |
| Atrophic areas in the macula |  |  |
| Epiretinal membrane(cellophane maculopathy) |  |  |
| Other |  |  |

1. **Other relevant ocular findings (Please tick all that applies)**

|  |  |  |
| --- | --- | --- |
|  | **RIGHT** | **LEFT** |
| Cataract |  |  |
| Pseudophakia |  |  |
| Posterior Capsular opacity |  |  |
| High IOP (please state IOP) |  |  |
| Other retinal pathology (please specify) |  |  |
| Other |  |  |

1. **Please include additional information you think relevant in the box below**

**To GP - This referral form is for your information only.  A copy has been emailed to RCHT macular service.**

**Community Optometrist - Please email this referral to** [**rcht.demac@nhs.net**](mailto:rcht.demac@nhs.net) **using a secure NHS e-mail account and send a copy to the patient's GP.**

Click here to enter text.