Please complete and fax to: 01204 441340.

Alternatively please email to: spamedica.referrals@nhs.net (secure only from an NHS.net account)

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| WET AMD RAPID ACCESS REFERRAL FORM |
| Name of Consultant: Fax Number: |
| PATIENT INFORMATION |
| Name: DOB: Hospital No.: (If known) Address:Contact Telephone No. |
| GP NAME GP Surgery  |
| Optometrist Details: (Please print do not use a stamp)Name: Practice:GOC No. Address:Tel: Fax: |
| Affected Eye: Right  |  | Left |  |  |
| Past history in either eye:Previous AMD Right LeftMyopia Right LeftOther Right Left |
| REFERRAL GUIDELINES |
| Presenting Symptoms in Affected Eye (one answer must be yes) Duration of visual loss: Please specify1. Vision loss Yes No
2. Spontaneously reported distortion Yes No
3. Onset scotoma 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 the affected eye ONLY, presence of:1. Macular haemorrhage Yes No

(preretinal, retinal, subretinal)1. Subretinal fluid Yes No
2. Exude Yes No

Please include OCT images if available |
| COMMENTS |
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