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| **WET AMD RAPID ACCESS REFERRAL FORM** |
| If you have a secure nhs.net address, please refer directly to uhsussex.sehmacularreferrals@nhs.net If you do not have a secure nhs.net account, please send to **AMD OFFICE, SUSSEX EYLE HOSPITAL, EASTERN ROAD, BRIGHTON, BN2 5BF.** **Has an OCT been completed? (if yes, please attach a copy with the referral)**  YES    NO    |
| **PATIENT DETAILS** |
| NAME: ADDRESS: CONTACT (TEL): | DOB: HOSPITAL NO: (If known) | GP NAME:GP PRACTICE: |
| **OPTOMETRIST DETAILS**  |
| NAME: GOC NO: CONTACT (TEL): | PRACTICE: ADDRESS: E-MAIL (nhs.net preferred): |
| **REFERRAL GUIDELINES** |
| **AFFECTED EYE:** (please mark the correct box with an ‘X’) | RIGHT:       | LEFT:       |
| PAST HISTORY IN EITHER EYE:PREVIOUS AMDMYOPIAOTHER (USE ADDITIONAL COMMENTS) | RIGHT:      RIGHT:      RIGHT:       | LEFT:      LEFT:      LEFT:       |
| **PRESENTING SYMPTOMS IN AFFECTED EYE** (***one answer must be yes, please mark the correct box with an ‘X’***) |
| Duration of symptoms:  |
| 1. Visual Loss
2. Spontaneously reported distortion
3. Onset of scotoma (or blurred spot) in central vision
 | YES   YES   YES    | NO   NO   NO    |
| **FINDINGS** Best corrected VA (**must be between 6/12 and 6/96 in affected eye)** |
| 1. Distance VA
2. Near VA
3. Macular drusen (either eye)
 | RIGHT:      /     RIGHT:     RIGHT:      | LEFT:      /     LEFT:     LEFT:      |
| **In the affected eye, presence of:** (one answer must be marked with an **‘X**’) |
| 1. Macular hemorrhage
2. Retinal fluid (please comment if noted on OCT\*)
3. Exudate
 | RIGHT:     RIGHT:     RIGHT:      | LEFT:     LEFT:     LEFT:      |
| **COMMENTS** |
| ADDITIONAL COMMENTS:  |

\*Please attach OCT image to the referral.