Practice Plus Group

Practice Plus Group Ophthalmology

Wet AMD Rapid access referral form

Name of consultant: Date of patient exam:

Patient details

Name: DOB: Hospital no.:

Address:

Contact telephone numbers:

GP name: **GP surgery:**

OPTOMETRIST DETAILS (please print, do not use a stamp)

Name: Practice:

GOC number: Address:

Tel: 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. Central vision loss	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	
4. I.O.P reading	Right		Left	

In the affected eye ONLY, presence of:

5. Macular haemorrhage (preretinal, retinal, subretinal)	Yes		No	
6. Subretinal fluid	Yes		No	
7. Exudate	Yes		No	

Comments