RBH WET AMD RAPID ACCESS REFERRAL FORM

Once complete, please email the form to:

Rbb-tr.amd@nhs.net

Date of referral:

Royal Berkshire NHS Foundation Trust

Patient Details

Name: **DOB:**

Address:

Telephone Number: **Hospital Number:** (if known)

GP: **GP Surgery:**

Optometrist Details

Name: **Practice Address:**

Telephone Number:

Affected Eye: **Right** ☐ **Left** ☐

Best Corrected Visual Acuity: **Right** ____/12 **Left** ____/12 **(in Snellen format please)**

BCVA must be between 6/12 and 6/96 (vision better than 6/12 may be referred if it is the patient's only eye)

Duration of symptoms: _____ **Was this an incidental finding? Y / N**

Signs and Symptoms in the affected eye	**(please tick)**	**Relevant history**	
Sudden onset Visual Distortion	☐	Cataract	R / L
Recent drop in VA	☐	Pseudophakia	R / L
Central scotoma	☐	Myopia	R / L
Macular Haemorrhage	☐	Glaucoma	R / L
Fluid noted on OCT	☐	Diabetes	R / L
Macular Drusen	☐	Amblyopia	R / L
AMD in other eye	☐	Dementia	Y / N

Further Details

Please only use this referral form for suspected wet AMD and Myopic CNV. Referrals should be sent to us within 1 working day and we aim to see patients within 2 weeks of receipt of referral. As our service demand is very high, efficient referrals that include OCT images, where possible, will aid the appropriate booking of clinics.

Thank you.

Telephone Number: 0118 322 7169 (option 5)