West Yorkshire and Harrogate
Health and Care Partnership

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Suspected "Wet" AMD Rapid Access Referral Form

Date of referral:	

Affected Eye: (please mark with an X)	Right Eye	Left Eye

Please provide history, signs, patient and optometrist details and send with images (if available)

Please record the presenting symptoms and signs in the **affected** eye.
At least one symptom or sign must be present. Please mark the correct box(es) with an X

Recent history of:

1. Visual loss	RE:		Duration:		LE:		Duration:	
2. Spontaneously reported distortion	RE:		Duration:		LE:		Duration:	
3. Central scotoma	RE:		Duration:		LE:		Duration:	

Findings / Signs:

1. Best corrected distance VA	Right:		Left:	
2. Near VA (if recorded)	Right:		Left:	
3. Macular drusen (either eye)	Right:		Left:	
4. Macular haemorrhage	Right:		Left:	
5. Macular exudate	Right:		Left:	
6. Abnormal OCT imaging	Right:		Left:	

Patient name:	**DOB:**	**NHS number:**

Address:	**Telephone number:**

Optometrist Name, GOC No and Telephone No:	**Optometry Practice Name and Address:**

Other comments:	

Bradford: Email macular.admin@nhs.net Tel: **01274 365222**
Calderdale/Huddersfield: Email cah-tr.referralsophthalmology@nhs.net or use the **CHFT Ophthalmology Referral Portal**
Harrogate: Email urgentapptcentre.hdft@nhs.net
Leeds: Refer via **CUES** or Email leedsth-tr.wetamdreferral@nhs.net
Wakefield: Email Myh-tr.ophthalmologyacutemyht@nhs.net