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| **RVI Wet AMD rapid access referral form** | | | | |
| **Name of Consultant:**  **Hospital Contact Details:** | | | | |
| **PATIENT DETAILS** | | | | |
| **NAME:**  **ADDRESS:**  **CONTACT TEL NOS:** | **DOB:** | | **HOSPITAL NO:**  **(If known)** | |
| **GP NAME:** | | **GP SURGERY:** | | |
| **OPTOMETRIST DETAILS:**  **NAME:**  **GOC NO:**  **TEL:** | | **PRACTICE:**  **ADDRESS:**  **FAX:** | | |
| **AFFECTED EYE:** | | **RIGHT:** | | **LEFT:** |
| **PAST HISTORY IN EITHER EYE**  **PREVIOUS AMD**  **MYOPIA**  **OTHER** | | **RIGHT:**  **RIGHT:**  **RIGHT:** | | **LEFT:**  **LEFT:**  **LEFT:** |
| **REFERRAL GUIDELINES** | | | | |
| **PRESENTING SYMPTOMS IN AFFECTED EYE (one answer must be yes, please mark the correct box with an ‘X’)**  **Duration of visual loss:** | | | | |
| 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 6/96 or better in affected eye)** | | | | |
| 1. **Distance VA** 2. **Near VA** 3. **Macular drusen (either eye)** | | **RIGHT:**      **/**      **RIGHT:**      **RIGHT:** | | **LEFT:**      **/**  **LEFT:**  **LEFT:** |
| **In the affected eye ONLY, presence of:** | | | | |
| 1. **Macular haemorrhage (preretinal, retinal, subretinal)** 2. **Subretinal fluid** 3. **Exudate** | | **RIGHT:**  **RIGHT:**  **RIGHT:** | | **LEFT:**  **LEFT:**  **LEFT:** |
| **Comments** | | | | |

**Images sent via email to -­ ­[tnu-tr.ophthalmologyreferrals@nhs.net](mailto:tr.MacularatSEI@nhs.net) YES NO**