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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 YES NO**