|  |  |
| --- | --- |
| **PATIENT DETAILS** |  |
| Name | Click here to enter text. | D.O.B | Click here to enter text. |
| Address | Click here to enter text. | Hospital Nr(If known) | Click here to enter text. |
| Telephone Nr | Click here to enter text. |
| GP Name | Click here to enter text. | GP Surgery | Click here to enter text. |
| **OPTOMETRIST DETAILS** |
| Name | Click here to enter text. | Practice | Click here to enter text. |
| GOC Nr | Click here to enter text. | Address | Click here to enter text. |
| Telephone Nr | Click here to enter text. | Fax/NHS.net email details | Click here to enter text. |
| **REFERRAL GUIDELINES** |
| **PRESENTING SYMPTOMS IN AFFECTED EYE** (one answer must be yes, please mark the correct box with an ‘X’)Date of Referral: Click here to enter text. Duration of visual loss: Click here to enter text. |
| AFFECTED EYE |  | RIGHT |[ ]  LEFT |[ ]
| **PAST HISTORY IN EITHER EYE** |
| Previous AMD |  | RIGHT  |[ ]  LEFT |[ ]
| Myopia |  | RIGHT |[ ]  LEFT |[ ]
| Other | Click here to enter text. | RIGHT |[ ]  LEFT |[ ]
| 1. Visual loss | YES |[ ]  NO |[ ]   |
| 2. Spontaneously reported distortion | 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 | Click here to enter text. | LEFT | Click here to enter text. |
| 2. Near VA |  | RIGHT | Click here to enter text. | LEFT | Click here to enter text. |
| 3. Macular drusen (either eye) | RIGHT | Click here to enter text. | LEFT | Click here to enter text. |
| In the affected eye ONLY, presence of: |
| 4. Macular haemorrhage (preretinal, retinal, subretinal) | RIGHT |[ ]  LEFT |[ ]
| 5. Subretinal fluid | RIGHT |[ ]  LEFT |[ ]
| 6. Exudate | RIGHT |[ ]  LEFT |[ ]
|  |
|  |
| **Please email completed form to** **stsft.seiapptsteam@nhs.net****Or fax to 0191 5699273/0191 5699627** | **Images included?** | **Yes** |[ ]  **No** |[ ]

