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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**](mailto:stsft.seiapptsteam@nhs.net)  **Or fax to 0191 5699273/0191 5699627** | | | | | | | | | **Images included?** | | | | | | | | | | **Yes** | |  | | **No** | |  |

