RVI Wet AMD rapid access referral form

DATE and TIME OF EXAMINATION:

Did Patient self-present with symptoms? Yes☐ No☐ Changes found routinely? Yes☐ No☐

PATIENT DETAILS

NAME: **ADDRESS:**

CONTACT TEL NOS:

GP NAME: **GP SURGERY:**

OPTOMETRIST DETAILS

NAME: **PRACTICE ADDRESS:**

GOC NO:

TEL:

AFFECTED EYE: **RIGHT: ☐** **LEFT: ☐**

PAST HISTORY:

PREVIOUS AMD	**RIGHT: Wet☐ Dry☐**	**LEFT: Wet☐ Dry☐**
MYOPIA	**RIGHT: ☐**	**LEFT: ☐**
PREVIOUS VA (if known)	**RIGHT:**	**LEFT:**

REFERRAL GUIDELINES

DURATION OF VISUAL LOSS:

PRESENTING SYMPTOMS IN AFFECTED EYE (one answer must be yes)

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 - give in Snellen)

1. Distance VA	**RIGHT:**	**LEFT:**
2. Near VA	**RIGHT:**	**LEFT:**
3. Macular drusen	**RIGHT: ☐**	**LEFT: ☐**

In the affected eye ONLY, presence of:

4. Macular haemorrhage (preretinal, retinal, subretinal)	**RIGHT: ☐**	**LEFT: ☐**
5. Subretinal fluid	**RIGHT: ☐**	**LEFT: ☐**
6. Exudate	**RIGHT: ☐**	**LEFT: ☐**

COMMENTS:

This form and any images to be sent as an attachment via email to –
tnu-tr.ophthalmologyreferrals@nhs.net **Images attached? Yes ☐ No ☐**
PLEASE SET UP A RECEIVED and READ RECEIPT TO CONFIRM EMAIL HAS BEEN ACTIONED