|  |  |  |
| --- | --- | --- |
| **WET AMD RAPID ACCESS REFERRAL FORM TO BIRMINGHAM AND MIDLAND EYE CENTRE**  | **DATE** |  |
| **COMPLETE ENTIRE FORM and FAX TO 0121 507 6726** |
| Patients surname |  | First name |  | GP name and address |
|  |  |  |
| Date of birth |  | Male/Female |  |
|  |  | (delete) |  |
| Address |  |  |
|  |  |  |
|  |  | Patient contact telephone no. |
|  |  |  |
|  |  | Patient Hospital no.(if known) |
| Postcode |  |  |
|  |
| **REFERRAL INFORMATION** |
| **Affected eye is……** | **right** |  |  | **left** |  |  |
|  |  |  |  |  |  |  |
| **Past history in either eye is….** | **R** |  |  | **L** |  |  |
| previous AMD |  |  |  |  |  |  |
| myopic |  |  |  |  |  |  |
| other |  |  |  |  |  |  |
| details:  |  |
| **Presenting symptoms in affected eye** (one answer must be yes) | PLEASE ANSWER YES/NO FOR AFFECTED EYE ONLY |
| less than 3 month history of |  |
| visual loss | yes |  |  | no |  |  |
| spontaneously reported distortion | yes |  |  | no |  |  |
| Onset of missing/blurred patch in vision | yes |  |  | no |  |  |
|  |  |  |  |  |  |  |
| **Findings**  | Corrected VA must be better than 6/96 in affected eye |
| Distance VA R |  | L |  |  Near VA R |  | L |  |  |
|  | PLEASE ANSWER YES/NO FOR AFFECTED EYE ONLY |
| macula drusen | yes |  |  | no |  |  |
| macular haemorrhage | yes |  |  | no |  |  |
| subretinal fluid | yes |  |  | no |  |  |
| exudate | yes |  |  | no |  |  |
| grey-green lesion | yes |  |  | no |  |  |
|  |  |  |  |  |  |  |
| **Short Comments** |
|  |
|  |
|  |
|  |
| **Name of optometrist/OMP** compulsory in block letters | **Address of practice** compulsory in block letters |
|  |  |
| **Signature**  |
|  |
|  |
|  | **date** |  |
| Please refer to guidance issued by Birmingham LOC | ✓ |