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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | | | | | ✓ |