iSIGHT
Excellence in eye care

WET AMD RAPID ACCESS REFERRAL FORM

ISIGHT CLINIC SOUTHPORT, DRAYTON HOUSE, 2 LULWORTH ROAD, SOUTHPORT

Fax number: 01704 550057 Telephone: 01704 563279

PATIENT DETAILS **Referral Date:**

NAME: DOB: HOSPITAL NO:

ADDRESS:

CONTACT TEL NOs:

GP NAME: **GP SURGERY:**

OPTOMETRIST DETAILS (please print, do not use a stamp)

NAME: PRACTICE:

GOC NO: ADDRESS:

TEL: FAX:

AFFECTED EYE: RIGHT ☐ LEFT ☐

PAST HISTORY IN EITHER EYE

PREVIOUS AMD	RIGHT	☐	LEFT	☐
MYOPIA	RIGHT	☐	LEFT	☐
OTHER	RIGHT	☐	LEFT	☐

REFERRAL GUIDELINES

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

Duration of visual loss:

Please specify:____

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	/	LEFT	/
2. Near VA	RIGHT	☐	LEFT	☐
3. Macular Drusen (either eye)	RIGHT	☐	LEFT	☐

In the affected eye ONLY presence of:

4. Macular haemorrhage (preretinal, retinal, subretinal)	YES	☐	NO	☐
5. Subretinal fluid	YES	☐	NO	☐
6. Exudate	YES	☐	NO	☐