The Royal Liverpool and Broadgreen University Hospitals NHS Trust

WET AMD RAPID ACCESS REFERRAL FORM

PATIENT DETAILS

NAME: DOB: / /
ADDRESS:
HOSPITAL / NHS N° (If Known)
POSTCODE:
CONTACT NUMBERS:

GP DETAILS
GP NAME: SURGERY: POSTCODE:

OPTOMETRIST DETAILS
NAME: PRACTICE:
GOC N°: ADDRESS:
TEL: POSTCODE:

DATE OF EYE EXAM: / /

AFFECTED EYE *Please* ***X*** *at least one* — **RIGHT** ☐ **LEFT** ☐

PAST HISTORY IN EITHER EYE

	RIGHT	LEFT
PREVIOUS DRY AMD		
PREVIOUS WET AMD		
CATARACT SURGERY		
OTHER		

If OTHER please comment

FINDINGS

PRESENTING SYMPTOMS IN AFFECTED EYE/S (one answer must be yes, please mark the correct box with an **X**)

		RIGHT	LEFT		
1. Asymptomatic on presentation	YES			NO	
2. Visual Loss (e.g. within a few weeks)	YES			NO	
3. Spontaneously reported distortion (metamorphopsia)	YES			NO	
4. Onset of scotoma (or blurred spot) in central vision	YES			NO	

Duration of any visual loss:

FINDINGS Please be aware that patients with Wet AMD and vision worse than **6/96** are not normally treated

	RIGHT	LEFT
1. Distance VA	/	/
2. Macular drusen		

In the affected eye/s (please mark with **X**) presence of:

	RIGHT	Location	LEFT	Location
3. Macular haemorrhage + Location				
4. Sub-retinal fluid or RPE elevation				
5. Exudates				

ADDITIONAL COMMENTS

Once completed please email or fax to one of the addresses below

EMAIL: AMDUrgentReferrals@rlbuht.nhs.uk
FAX: 0151 706 5624
PHONE: 0151 706 3994 for any queries

Internal office use only
Date referral received / /

Reciept will be acknowledged, if not please telephone 0151 706 3994