WET MACULAR DEGENERATION REFERRAL FORM

We would encourage the Opticians to use this form to make DIRECT referral to eye CAS for suspect WET AMD, accompanied with OCT/ FF images if available.

Patient Name: **DOB:**

Address:

Hospital/NHS Nos **Contact Tel:**

Referral from ☐ **Optician** ☐ **GP**

Practice e-mail

Telephone

Referral Date:

Visual acuity* :

Right eye______________________ Left eye _________________________

Duration of symptoms*

o **Sudden onset visual distortions*** o **Sudden near vision drop*** o **Central scotoma***	o **Macular drusen*** o **Macular haemorrhage*** o **Macular elevation (on OCT)***
Ocular history o **Dry AMD** o **Myopia** o **Amblyopia** o **Glaucoma**	**Medical history** o **Hypertension** o **Heart disease/angina** o **Kidney disease** o **Smoking**

*The information marked with asterisk is mandatory

For office use only: BOOK in MR clinic with OCT, F2F, within 2 weeks ☐

Please email this form with images attached to: eye.clinic@nhs.net ASAP