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| **WET AMD RAPID ACCESS REFERRAL FORM** | | | | |
| If you have a secure nhs.net address, please refer directly to [uhsussex.sehmacularreferrals@nhs.net](mailto:uhsussex.sehmacularreferrals@nhs.net) If you do not have a secure nhs.net account, please send to **AMD OFFICE, SUSSEX EYLE HOSPITAL, EASTERN ROAD, BRIGHTON, BN2 5BF.**  **Has an OCT been completed? (if yes, please attach a copy with the referral)**  YES    NO | | | | |
| **PATIENT DETAILS** | | | | |
| NAME:  ADDRESS:  CONTACT (TEL): | DOB:  HOSPITAL NO:  (If known) | | GP NAME:  GP PRACTICE: | |
| **OPTOMETRIST DETAILS** | | | | |
| NAME:  GOC NO:  CONTACT (TEL): | | PRACTICE:  ADDRESS:  E-MAIL (nhs.net preferred): | | |
| **REFERRAL GUIDELINES** | | | | |
| **AFFECTED EYE:** (please mark the correct box with an ‘X’) | | RIGHT: | | LEFT: |
| PAST HISTORY IN EITHER EYE:  PREVIOUS AMD  MYOPIA  OTHER (USE ADDITIONAL COMMENTS) | | RIGHT:  RIGHT:  RIGHT: | | LEFT:  LEFT:  LEFT: |
| **PRESENTING SYMPTOMS IN AFFECTED EYE** (***one answer must be yes, please mark the correct box with an ‘X’***) | | | | |
| Duration of symptoms: | | | | |
| 1. Visual Loss 2. Spontaneously reported distortion 3. Onset of scotoma (or blurred spot) in central vision | | YES  YES  YES | | NO  NO  NO |
| **FINDINGS** Best corrected VA (**must be between 6/12 and 6/96 in affected eye)** | | | | |
| 1. Distance VA 2. Near VA 3. Macular drusen (either eye) | | RIGHT:      /      RIGHT:      RIGHT: | | LEFT:      /  LEFT:  LEFT: |
| **In the affected eye, presence of:** (one answer must be marked with an **‘X**’) | | | | |
| 1. Macular hemorrhage 2. Retinal fluid (please comment if noted on OCT\*) 3. Exudate | | RIGHT:  RIGHT:  RIGHT: | | LEFT:  LEFT:  LEFT: |
| **COMMENTS** | | | | |
| ADDITIONAL COMMENTS: | | | | |

\*Please attach OCT image to the referral.