Please complete and fax to: 01204 441340.

Alternatively please email to: spamedica.referrals@nhs.net (secure only from an NHS.net account)

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| WET AMD RAPID ACCESS REFERRAL FORM | | | | |
| Name of Consultant: Fax Number: | | | | |
| PATIENT INFORMATION | | | | |
| Name: DOB: Hospital No.:  (If known) Address:  Contact Telephone No. | | | | |
| 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. Vision loss Yes No 2. Spontaneously reported distortion Yes No 3. Onset scotoma 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:   1. Macular haemorrhage Yes No   (preretinal, retinal, subretinal)   1. Subretinal fluid Yes No 2. Exude Yes No   Please include OCT images if available | | | | |
| COMMENTS | | | | |
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