WET AMD RAPID ACCESS REFERRAL FORM

Name of Consultant: **Fax Number:**

PATIENT DETAILS

NAME: DOB: HOSPITAL No: (If known)

ADDRESS:

CONTACT PHONE NUMBERS:

GP NAME: **GP SURGERY:**

OPTOMETRIST DETAILS:

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, please mark the correct box with an 'X')

Duration of visual loss:

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:	

ADDITIONAL COMMENTS

Macular Disease Society

THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

THE COLLEGE OF OPTOMETRISTS

RNIB

This form is intended for use by optometrists and general practitioners. It is based on the work of the Thames Valley Macular Group, namely: Susan Downes, Consuela Moorman, Lyn Jenkins and Sarah Lucie Watson. This group has audited the results of rapid access referral using this form and The Royal College of Ophthalmologists is keen to highlight and promote examples of good practice