

**WET AMD RAPID ACCESS REFERRAL FORM**

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| **HOSPITAL PROVIDER** |  |
| **PATIENT DETAILS** |
| **NAME** |  | **DOB** |  |
| **ADDRESS** |  | **HOSP No****(if known)** |  |
| **CONTACT TEL** |  | **NHS No** |  |
| **GP NAME** |  | **GP SURGERY** |  |
| **OPTOMETRIST DETAILS**  |
| **NAME** |  | **PRACTICE** |  |
| **GOC NO** |  | **ADDRESS** |  |
| **TEL** |  |
| **AFFECTED EYE** | **RIGHT** |  | **LEFT** |  |
| PAST HISTORY IN EITHER EYE | **RIGHT** |  | **LEFT** |  |
| 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 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** |  |
|  **Comments** |
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Please email to wn.ophthalmology@nhs.net