

**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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