WET AGE RELATED MACULAR DEGENERATION RAPID ACCESS REFERRAL FORM				DATE 12/01/2017
Please Select Consultant by ticking appropriate box			**FAX No:**	**01270 273463**
			FAX No:	**01625 440002**

Patient Details			
Patient Name:	«FirstNames» «Surname»	Date of Birth:	NHS Number:
		«DateOfBirth»	
Patient Address:	«Address1» «Address2» «Town» «Postcode»	Contact Telephone Nos:	
		«telhome» «telmobile»	
GP Name:	«GPsName»	GP Code:	

Optometrist Details (Please print, do not use a stamp)			
Optometrist Name:	«Optician»	GOC No:	«OpticianHARef»
Practice Name & Address:		Telephone No:	Fax No:

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. 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 affected eye ONLY, presence of:		
4. Macular haemorrhage (perentinal, retinal, subretinal)	Yes ☐	No ☐
5. Subretinal fluid	Yes ☐	No ☐
6. Exudate	Yes ☐	No ☐

COMMENTS