SEI Wet AMD rapid access referral form

Name of Consultant:

Hospital Contact Details:

PATIENT DETAILS

NAME: DOB: HOSPITAL NO: (If known)

ADDRESS:

CONTACT TEL NOS:

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)	RIGHT: ☐	LEFT: ☐
5. Subretinal fluid	RIGHT: ☐	LEFT: ☐
6. Exudate	RIGHT: ☐	LEFT: ☐

Comments

ADDITIONAL COMMENTS:

Images sent via email to - cis-tr.MacularatSEI@nhs.net **YES** ☐ **NO** ☐
Please fax the filled in form to 0191 5699273/0191 5699627

THE COLLEGE OF OPTOMETRISTS