**Wet Macular Degeneration Rapid Access Referral Form**

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|  | **Hospital Contact Details: *(Please send completed referral to…)***  CHFT Ophthalmology Outpatients Email Address – [Ophthalmology.CHFT@nhs.net](mailto:Ophthalmology.CHFT@nhs.net) |

**Please ensure that all patient details, referring GP and/or Optometrist are entered**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | |  | | |
| Name: | | |  | | | | DOB: | | | |  | | | | | Hospital / NHS number: | | |  | | |
| «Title» «Forenames» «Surname» | | | | | |  | «DateOfBirth» | | | | | | |  | |  | | | |  | |
|  | | | | | |  |  | | | | | | |  | |  | | |  | | |
| Address: | | | | | | | | | | | | | |  | | | | |  | | |
| «Address1», «Locality», «Town», «PostCode» | | | | | | | | | | | | | | | | | | | |  | |
|  | | | |  |  | | | | | | | | | | | | | |  | | |
| Home Tel No: | «HomeTel» | | | | | | Mobile Tel No: | | | | | | «MobTel» | | | | | | |  | |
|  | | | |  |  | | | | | | | | | | | | | |  | | |
| GP Name: | | | |  | GP Surgery: | | | | | | | | | | | | | |  | | |
| «GPFullName» | | | |  | «GPAdd1», «GPAdd2», «GPAdd3», «GPAdd4», «GPPCode» | | | | | | | | | | | | | | |  | |
|  |  | |
| Referring Optometrist Name: | | | |  | Optometry Practice Name and Address: | | | | | | | | | | | | | |  | | |
| «Optician1» | | | |  | Add Practice address here | | | | | | | | | | | | | | |  | |
|  |  | |
|  | | | | | | | | | | | | | | | | | | |  | | |
| Telephone No: | | Add practice phone number here | | | | | |  | GOC No: | | | | | «Optician1GOCNo» | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | |
| Optometrist Email Address: | | | | | Add Practice NHS email here | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | |  | | |
| Affected eye: | | | | | | Right | | | | NO | |  | | | Left | | NO |  | | | |

**Past history in either eye**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Previous AMD | Right: | NO |  | Left: | NO |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Myopia | Right (DS): |  |  | Left (DS): |  |  |

|  |  |
| --- | --- |
| Other (please specify) |  |

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| **REFERRAL GUIDELINES** |

Presenting symptom in affected eye (one answer must be yes. Please mark the correct box with an X)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | **RE** | **LE** | |
|  |  |  |  |  |  |  |  |  |
| 1. Visual loss | RE: | NO |  | LE: | NO | Duration: |  |  | |
|  | | | | | | | | |
| 2. Spontaneously reported distortion | RE: | NO |  | LE: | NO | Duration: |  |  | |
|  | | | | | | | | |
| 3. Onset of scotoma (or blurred spot) in central vision | RE: | NO |  | LE: | NO | Duration: |  |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Distance VA (best corrected) | Right : | «RightVA1» |  | Left : | «LeftVA1» |  | |
|  | | | | | | |
| 2. Near VA | Right : | «NearRightVA1» |  | Left : | «NearLeftVA1» |  |
|  | | | | | | |
| 3. Macular drusen (either eye) | Right : | NO |  | Left : | NO |  |

**In the affected eye only, the presence of:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 4. Macular Haemorrhage | Right: | NO |  | Left : | NO |  |
|  |  |  |  |  |  |  |
| 5. Subretinal fluid | Right: | NO |  | Left : | NO |  |
|  |  |  |  |  |  |  |
| 6. Exudate | Right: | NO |  | Left : | NO |  |

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| **ADDITIONAL COMMENTS** |

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| **Signature of referrer** | *«Optician1»* |  | **Date** | **«TodaysDate»** |