**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  |

**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 |  |

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

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| --- | --- |
| 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: |  |  |

|  |  |  |  |  |  |  |
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|  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»** |