SUSPECTED WET AMD RAPID ACCESS REFERRAL FORM

North West Anglia
NHS Foundation Trust

The completed form must be sent via NHSmail to the designated mailbox only **nwangliaft.wetamd@nhs.net**

Date of referral

Patient details

First name | Last name

Date of birth | NHS №

Tel (home) | Tel (mob)

Address

Optometrist details

Name | Practice

GOC №

Tel | Email

Address

GP Details

Name | Surgery

Refraction

best corrected VA must be 6/96 or better in the affected eye

Date of refraction

	VA distance uncorrected	SPH	CYL	AXIS	VA distance corrected
RE					
LE					

Presenting symptoms and signs

Duration of visual loss:

1. Visual loss	☐ Right eye	☐ Left eye
2. Spontaneously reported distortion	☐ Right eye	☐ Left eye
3. Onset of scotoma or blurring of central vision	☐ Right eye	☐ Left eye
4. Macular drusen	☐ Right eye	☐ Left eye
5. Macular haemorrhage (preretinal / retinal / subretinal)	☐ Right eye	☐ Left eye
6. Subretinal fluid	☐ Right eye	☐ Left eye
7. Exudate	☐ Right eye	☐ Left eye

Additional comments

☐ OCT attached ☐ Photographs attached