

Name of consultant:

Hospital contact details:

Please ensure that all patient details, referring GP and/or optometrist are entered.

## Patient details

Name:  Date of birth:  Hospital number (if known):

Contact telephone number(s):  Address:

GP name:  GP surgery:

Optometrist name:  Optometry practice name and address:

GOC number:  Telephone number:  Fax number:

Affected eye [Please mark the correct box with an X] 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]

1. Visual loss Yes:  No:   
Duration of visual loss:   
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:

## Additional comments

Signature of referrer

[Or name and registration number if submitting electronically]

Date