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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WET AMD RAPID ACCESS REFERRAL FORM** | | | | | | | | | | | | | | | | | |
| **Name of Consultant:** | | | |  | | | **Fax Number:** | | | | | |  | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | |
| NAME: | | | | | | DOB: | | | | HOSPITAL No: (If known) | | | |  | | | |
| ADDRESS: | | | | | | | | | | | | | | | | | |
| CONTACT PHONE NUMBERS: | | | | | | | | | | | | | | | | | |
| **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) | | | | | | | | | YES: | |  |  | | NO: |  |  | |
| 5. Subretinal fluid | | | | | | | | | YES: | |  |  | | NO: |  |  | |
| 6. Exudate | | | | | | | | | YES: | |  |  | | NO: |  |  | |
| **ADDITIONAL COMMENTS** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |



This form is intended for use by optometrists and general practitioners. It is based on the work of the Thames Valley Macular Group, namely: Susan Downes, Consuela Moorman, Lyn Jenkins and Sarah Lucie Watson. This group has audited the results of rapid access referral using this form and The Royal College of Ophthalmologists is keen to highlight and promote examples of good practice