SpaMedica

NHS

Please complete and fax to: 0161 835 1704.
Alternatively please email to: Referrals@spamedica.co.uk or spamedica.referrals@nhs.net

WET AMD RAPID ACCESS REFERRAL FORM

Name of Consultant:
Fax Number:

PATIENT INFORMATION

Name: DOB: Hospital No.: (If known)

Address:

Contact Telephone No.

GP NAME **GP Surgery**

Optometrist Details: (Please print do not use a stamp)

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)
Duration of visual loss:
Please specify

1. Vision loss	**Yes**		**No**	
2. Spontaneously reported distortion	**Yes**		**No**	
3. Onset scotoma 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. Exude	Yes		No	

Please include OCT images if available

COMMENTS