**WET MACULAR DEGENERATION REFERRAL FORM**

We would encourage the Opticians to use this form to make DIRECT referral to eye CAS for suspect WET AMD, accompanied with OCT/ FF images if available.

Patient Name: DOB:

Address:

Hospital/NHS Nos Contact Tel:

Referral from Optician GP

Practice e-mail

Telephone

Referral Date:

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| **Visual acuity\* :****Right eye\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Left eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Duration of symptoms\*** |
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|  |  |
| --- | --- |
| * **Sudden onset visual distortions\***
* **Sudden near vision drop\***
* **Central scotoma\***
 | * **Macular drusen\***
* **Macular haemorrhage\***
* **Macular elevation ( on OCT)\***
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| **Ocular history*** **Dry AMD**
* **Myopia**
* **Amblyopia**
* **Glaucoma**
 | **Medical history*** **Hypertension**
* **Heart disease/angina**
* **Kidney disease**
* **Smoking**
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\*The information marked with asterisk is mandatory

For office use only: BOOK in MR clinic with OCT, F2F, within 2 weeks □

**Please email this form with images attached to:** **eye.clinic@nhs.net** **ASAP**