**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:

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

\*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**](mailto:eye.clinic@nhs.net) **ASAP**