Wet AMD Rapid Access Referral Form.

https://essex-loc.org

Consultant Name:
Hospital Name:

Patient Surname:
Address:
Postcode:

First Name:
DOB:
NHS No(if Known):
Daytime tel no:
and/or Px Email:

GP Name:

GP Surgery:

Optometrist Name:
Practice:
Address:
Postcode:

G0C Number
Tel no:
Fax no:
Email:

Affected Eye:

	Right:	Left:
	☐	☐

Past History in either eye:

	Right:	Left:
Previous AMD:	☐	☐
Myopia:	☐	☐
Other:	☐	☐

Referral Clinical Details and Guidelines:

Please specify duration of visual loss in affected eye (if any) :

Presenting symptoms in the affected eye*:

*One answer must be 'YES', please tick the correct box)

YES ☐	NO ☐	1. Visual Loss
YES ☐	NO ☐	2. Spontaneously reported Distortion
YES ☐	NO ☐	3. Onset of Mascot (or blurred spot) in central vision

Findings:

(Best corrected VA **must** be 6/96 or better in the affected eye)

	Right:	Left:
1. Distance VA	/	/
2. Near VA		
3. Macular drusen (either eye)	☐	☐

In the affected eye ONLY, presence of:

	Right	Left
4.Macular haenorrhage(preretinal,retinal, sub retinal)	☐	☐
5. Subretinal Fluid	☐	☐
6. Exudate	☐	☐

Comments:

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