   

**North West Macular Service**

**Wet AMD Rapid access referral form**

**Fax to 01706 638594 or via nhs.net email to cuk.northwestmacular@nhs.net**

# Referral to Mrs Karen Goodall Please tick as applicable

Date: 

Urgent (treat all suspected Wet AMD as urgent) New patient Rapatriated patient

#  Patient details

Name: DOB:

Address:

NHS number (if known):





Contact tel nos.: GP Name: GP practice:

#  Clinical presentation

|  |  |  |  |
| --- | --- | --- | --- |
| **AFFECTED EYE:****PRESENTING SYMPTOMS IN AFFECTED EYE** | Right | Left**PAST HISTORY** |  |
| 1. Visual loss
2. Distorted vision
3. Blurring of central vision
4. Duration of visual loss (time in hrs/days):
 |  | Previous AMD Myopia Glaucoma/OHTOther (please specify): |
| **FINDINGS**1. Current distance BCVA |  | **RIGHT EYE**/ | **LEFT EYE**/ |
| 2. Previous distance BCVA - Date: |  | / | / |
| 1. Presence of macular drusen
2. Distortion on Amsler grid
 |  |

1. Macular haemorrhage, sub-retinal fluid or exudate
2. I.O.P. both eyes / mmHg

