Practice Plus Group

Practice Plus Group Ophthalmology

Wet AMD Rapid access referral form

Name of referring practice: Date of patient exam:

Patient details

Name: DOB: NHS number:

Address:

Contact telephone number:

GP name: **GP surgery:**

GP address:

GP telephone number:

OPTOMETRIST DETAILS (please print, do not use a stamp)

Name: Practice:

GOC number: 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. Visual loss Yes ☐ No ☐
2. Central vision loss Yes ☐ No ☐
3. Onset of scotoma (or blurred spot) 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 ☐
4. I.O.P reading Right ☐ Left ☐

In the affected eye ONLY, presence of:

5. Macular haemorrhage (preretinal, retinal, subretinal) Yes ☐ No ☐
6. Subretinal fluid Yes ☐ No ☐
7. Exudate Yes ☐ No ☐

Comments/additional requirements