Wet AMD rapid access referral form

University Hospitals Birmingham NHS
NHS Foundation Trust

Name of consultant:

Hospital contact details:

Please ensure that all patient details, referring GP and/or optometrist are entered.

Patient details

Name:

Date of birth:

Hospital number (if known):

Contact telephone number(s):

Address:

GP name:

GP surgery:

Optometrist name:

Optometry practice name and address:

GOC number:

Telephone number:

Fax number:

Affected eye [Please mark the correct box with an **X**] 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. Please mark the correct box with an **X**]

1. Visual loss Yes: ☐ No: ☐
   Duration of visual loss:
2. Spontaneously reported distortion 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: ☐

In the affected eye **only**, presence of:

4. Macular haemorrhage (preretinal, retinal, subretinal) Right: ☐ Left: ☐
5. Subretinal fluid Right: ☐ Left: ☐
6. Exudate Right: ☐ Left: ☐

Additional comments

Signature of referrer
[Or name and registration number if submitting electronically]

Date