WET AMD RAPID ACCESS REFERRAL FORM

Salisbury District NHS Foundation Trust Hospital
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PATIENT DETAILS

NAME : DOB : HOSPITAL NO: (If known)

ADDRESS :

CONTACT TEL NOS :

GP NAME: GP SURGERY:

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

NAME : PRACTICE :

GOC NO: 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.	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)	YES ☐	NO ☐
5.	Subretinal fluid	YES ☐	NO ☐
6.	Exudate	YES ☐	NO ☐

Comments

Macular Disease Society

THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

THE COLLEGE OF OPTOMETRISTS

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