Gloucestershire Ophthalmology Service: **WET AMD RAPID ACCESS REFERRAL FORM**

For completion by Optometrist

Patient details Name: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

Hospital No (if known) _____

Address: _____

_____ Postcode: _____

Telephone: Home: _____ Work: _____ Occupation: _____

Referring Optometrist

GOC No: _____

General Practitioner

Name: _____

Practice Name: _____

Address: _____

_____Postcode: _____

Telephone: _____

AFFECTED EYE:	**RIGHT ☐**	**LEFT ☐**
PREVIOUS HISTORY IN EITHER EYE		
Previous AMD	Right ☐	Left ☐
Myopic	Right ☐	Left ☐
Other:	Right ☐	Left ☐
Referral Guidelines		
PRESENTING SYMPTOMS IN AFFECTED EYE (one answer must be 'yes')		
Less than **3 month** history of:		
1. Visual Loss	Yes ☐	No ☐
2. **Spontaneously** reported distortion	Yes ☐	No ☐
3. Onset missing patch / blurring in central vision	Yes ☐	No ☐
FINDINGS 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 macular:		
4. Haemorrhage	Yes ☐	No ☐
5. Subretinal fluid	Yes ☐	No ☐
6. Exudate	Yes ☐	No ☐

CURRENT REFRACTION: Distance: R …… L ……..……

Date: ……..…… Near: R ……..…….. L ……..……..……..

OTHER COMMENTS:	FAX TO : 0300 4228531 OR EMAIL TO ann.friend1@nhs.net **ONLY IF YOU HAVE ACCESS TO NHS.net**

I request that my referring optometrist receives a report from the Hospital Eye Department: Yes ☐ No ☐

Patient's signature:	Print name:	
Optometrist's signature:	Print name:	**Date: / /**
Gloucestershire Royal Hospital: Central Booking Office, 4th floor, Victoria Warehouse. The Docks, Gloucester GL1 2EL		
Patients will be contacted within 48 hours of receipt of this referral, Monday to Friday and an appointment will be sent.	**Copy sent to GP:** **Yes ☐ No ☐**	