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

**For completion by Optometrist**

**Patient Details**

|  |  |  |
| --- | --- | --- |
| Name:  | DOB | Male/Female |
| Hospital No (if known)  |
| Address:  | Postcode: |
| Tel: Home:  | Tel: Work:  | Occupation:  |
| **Referring Optometrist** | **General Practitioner** |
| Name: | Name: |
| Practice Name: | Practice Name: |
| Address: | Address: |
| Postcode: | Postcode: |
| Telephone: | nhs.net email: | Telephone:  |
| GOC No: | nhs.net email: |

|  |  |  |
| --- | --- | --- |
|  **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:  | EMAIL TO ghn-tr.AMDteam@nhs.netONLY 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, 8 Pulman Court, Great Western Road, Gloucester, GL1 3ND |
| 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  |

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST AMD Rapid Access REFERRAL FORM – Version 6.4 January2022