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.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, 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	