Gloucestershire Hospitals NHS
NHS Foundation Trust

URGENT MEDICAL RETINA REFERRAL FORM

Please email completed form to ghn-tr.AMDteam@nhs.net with any relevant images attached.

Patient Name:	DOB:	Date:
Hospital / NHS No. (if known):		
Address:		Postcode:
Tel: Home:	Tel: Work:	Occupation:

Referring Optometrist		**General Practitioner**
Name and GOC no:		Name:
Practice Name:		Practice Name:
Address:		Address:
Postcode:		Postcode:
Telephone:	nhs.net email:	Telephone:

Provisional Diagnosis*

nAMD ☑	
RVO ☐	(Please ensure copy of this letter is sent to the GP so that BP, serum glucose, FBC and ESR can be carried out ASAP)
Other suspect urgent Medical Retina (please specify) ☐	Notes:

*Please **do not** use this for referrals that are best managed by the Vitreo-Retinal Team i.e., ERMs, Macular Holes etc. These are best sent as a referral to ghn-tr.cboreferrals@nhs.net from a nhs.net acct*

Clinical Signs

	RIGHT	**LEFT**	Comments
Rx			
BCVA			
Symptomatic			If yes, duration of symptoms?
Macular haemorrhage			
Drusen			
Exudate			
Sub/intra-retinal fluid			OCT performed: YES ☐ NO ☐ If yes is it attached? YES ☐ NO ☐
Any other relevant features?			
Any other relevant information? (eg is Pt diabetic, previous high myope, previously known to HES etc)			