

**Practice Plus Group Ophthalmology**

Wet AMD Rapid access referral form

Name of referring practice:

Date of patient exam:

Name:

DOB:

NHS number:

Address:

Contact telephone number:

GP address:

GP telephone number:

**OPTOMETRIST DETAILS** (please print, do not use a stamp) Name: GOC number:

Practice: Address:

Tel:

**AFFECTED EYE:**

Past history in either eye Previous AMD

Myopia

Fax:

Right

Left

Right Right Right

Left Left Left

Other

**PRESENTING SYMPTOMS IN AFFECTED EYE** (one answer must be ‘yes’)

Duration of visual loss:

Please specify

1.

2.

3.

Visual loss Central vision loss

Onset of scotoma (or blurred spot) in central vision

Yes Yes Yes

No No No

**FINDINGS** Best corrected VA (must be 6/96 or better in affected eye)

1.

2.

3.

4.

Distance VA Near VA

Macular drusen (either eye)

I.O.P reading

Right Right Right Right

Left Left Left Left

In the affected eye ONLY, presence of:

5.

6.

7.

Macular haemorrhage (preretinal, retinal, subretinal)

Yes Yes Yes

No No No

Subretinal fluid Exudate

Review July 24 Version 2.

PPG1034 Jul.22 (0309)

**Comments**

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**Referral guidelines**

**GP name: GP surgery:**

**Patient details**