

WET AMD Rapid access referral form

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Harrogate and District

NHS Foundation Trust

| | | | |
|-------------------------|--|-------------|--|
| Patients Details | | Date | |
| Name | | D.O.B | |
| Address | | Hosp. No | |
| | | GP | |
| Contact number | | | |

| | |
|-----------------------------|-------------|
| Optometrists details | |
| Practice | Optometrist |
| Address | GOC number |
| Tel | |

| Spectacle Prescription | | | | | | | | |
|------------------------|-----|-----|------|-------|----|-----|-----|--|
| | Sph | Cyl | Axis | Prism | VA | Add | NVA | |
| R | | | | | | | | |
| L | | | | | | | | |

| | | | | |
|---------------------------------------|-------|--------------------------|------|--------------------------|
| Affected eye: | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Previous History in either eye | | | | |
| Previous AMD | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Myopic | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Other | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |

| Referral Guidelines | | | | |
|--|-------|--------------------------|------|--------------------------|
| Presenting symptoms in affected eye (one box must be ticked) | | | | |
| Less than 3 months history of: | | | | |
| Vision loss | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Spontaneously reported distortion | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Onset of missing patch/blurring central vision | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| Findings | | | | |
| Macular Drusen (either eye) | Right | <input type="checkbox"/> | Left | <input type="checkbox"/> |
| In the affected eye only: | | | | |
| Macular Haemorrhage | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Sub-Retinal Fluid | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Exudate | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Comments: | | | | |

| | | |
|-----------------------|-----------------------------|-----------|
| HDFT use only: | Rapid access Outcome | |
| Referral seen by : | | |
| Clinic date: | OCT date: | FFA Date: |
| | | Feedback: |