North West London Wet-AMD/CNVM 2-Week Fast-Track Fax Referral Pathway

Date: ____________________

□ **Central Middlesex Hospital**
(Ms. Evelyn Mensah)
Tel: 020 8453 2252
Fax: 020 8963 7170

□ **Charing Cross Hospital**
(Ms. Teresa Richardson)
Answer Phone: 020 3312 7724
Fax: 020 3312 3656

□ **Chelsea & Westminster Hospital**
(Mr. Nigel Davis)
Tel: 020 8746 5042
Fax: 020 3315 8846

□ **Hillingdon Hospital**
(Ms. Sheena George)
Tel: 01895 279 240
Mobile: 079175 13400
Fax: 01895 279 247

□ **Moorfields Eye Hospital City Road Retinal Therapy Unit**
(Mr. Robin Hamilton)
Tel: 020 7566 2311
Fax: 020 7566 2351

□ **Mount Vernon Hospital**
(Mr. Nicholas Lee)
Tel: 01895 279 240
Mobile: 079175 13400
Fax: 01895 279 247

□ **Western Eye Hospital**
(Mr. Saad Younis)
Answer Phone: 020 3312 7724
Fax: 020 3312 3656

For urgent attention of patient's GP:
I am referring urgently this patient with Wet-AMD/CNVM. Please kindly **fax this patient's medical summary** to the selected eye department together with this referral without delay.

To Hospital Eye Department:
I am referring this patient urgently for Wet-AMD/CNVM. I attached the GOS18 form with additional clinical information.

Referrer's Signature:

Patient Information

Surname: ____________________

First Name: ____________ Title: ____________

Tel: ____________ DOB: ____________

Address: ____________________

____

Referring Optometrist/Ophthalmologist

Name: ____________________

GOC No.: ____________________

Tel: ____________ Fax: ____________

Address: ____________________

____

GP Details

Name: ____________________

Practice: ____________________

Fax: ____________________