LUTON & DUNSTABLE HOSPITAL

WET AMD RAPID ACCESS REFERRAL FORM

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PATIENT

NAME:		DOB:		Hospital NO: (if known)	
ADDRESS:					
Phone	Home	Work		Mobile	

GP NAME: **GP SURGERY:**

Optometrist details:
Name **GOC number** **Phone**

Practice name and address

Date of referral:

AFFECTED EYE: (please select) **-- SELECT --**

Past history of wet AMD ☐
Known dry AMD ☐
Myopic ☐
Other ☐
Additional information:

REFERRAL GUIDELINES

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

		Duration
1.	Visual loss	--SELECT--
2.	Spontaneously reported visual distortion	--SELECT--
3.	Scotoma (black or grey spot) in central vision	--SELECT--

Findings

		Right	Left
	Corrected visual acuity		
1.	Macular Haemorrhage	☐	☐
2.	Subretinal fluid	☐	☐
3.	Exudate	☐	☐

Patients will be contacted within 48 hours of receipt of this referral Monday-Friday