

Wet ARMD Referral Form

Please note – all fields are mandatory and should be **completed electronically**. Incomplete forms will be returned and may result in delays in arranging the appointment.

Patient Details	
Name:	Date of birth:
Address:	Phone number:
Post code:	NHS number (if known):
GP Details:	
GP Name:	GP Surgery:
Optometrist Details:	
Optometrist Name:	Optometrist Practice:
Address :	Date of examination:

1. Please complete the details about refraction

	RIGHT				LEFT			
	Sph	Cyl	Axis	VA	Sph	Cyl	Axis	VA
Distance								
Near								
Tonometry (if performed)	RIGHT				LEFT			
	AT ☐ NCT ☐				mm HG			

2. What is the main reason for referring this patient (please click the relevant box)?

a)	I am highly suspicious that this patient has Wet ARMD	☐
b)	This patient has mainly dry ARMD but I suspect they may have Wet ARMD	☐
c)	I suspect this patient has Branch Retinal Vein Occlusion (BRVO)	☐
d)	I suspect this patient has Central Retinal Vein Occlusion (CRVO)	☐
e)	I suspect this patient has Diabetic Macular Oedema (DMO)	☐

3. Which eye has been affected

a)	Left	☐
b)	Right	☐
c)	Both	☐

4. How long has the patient had symptoms for?

a)	For days or months
b)	Patient is not symptomatic but I found abnormality on a routine check ☐

5. What symptoms does this patient have? (Please tick all that applies)

	RIGHT	LEFT
Decrease/blurred vision	☐	☐
Distortion of vision	☐	☐
Difficulty reading	☐	☐
No symptoms	☐	☐
Other	☐	☐

6. What is your clinical observation? (Please tick all that applies)

	RIGHT	LEFT
Amsler distortion	☐	☐
Macular haemorrhage	☐	☐
Macular Drusen	☐	☐
Retinal fluid in macula	☐	☐
Retinal fluid on OCT retinal scan	☐	☐
Atrophic areas in the macula	☐	☐
Epiretinal membrane(cellophane maculopathy)	☐	☐
Other	☐	☐

7. Other relevant ocular findings (Please tick all that applies)

	RIGHT	LEFT
Cataract	☐	☐
Pseudophakia	☐	☐
Posterior Capsular opacity	☐	☐
High IOP (please state IOP)	☐	☐
Other retinal pathology (please specify)	☐	☐
Other	☐	☐

8. Please include additional information you think relevant in the box below

Community Optometrist - Please email this referral to rcht.demac@nhs.net using a secure NHS e-mail account and send a copy to the patient's GP.

To GP - This referral form is for your information only. A copy has been emailed to RCHT macular service.