DBTH WET AMD RAPID ACCESS REFERRAL FORM

Once complete, please email the form to:
dbth.wetamd@nhs.net **Tel: 01302 644283**

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Date of referral :

Patient Details

First name : | **Last name :**
D.O.B : | **NHS №:**
Tel (home) : | **Tel (mob) :**
Address :

Optometrist Details

Name : | **Practice :**
GOC №:
Tel : | **Email :**
Address :

GP Details

Name : | **Surgery :**

Refraction - *best corrected VA (must be 6/96 or better in the affected eye)*

Date of refraction: **Date of referral :**

	VA distance uncorrected	SPH	CYL	AXIS	PRISM	BASE	VA distance corrected
RE							
LE							

Presenting Symptoms and signs

Duration of visual loss: **Days** **Weeks** **Months**

1. Visual loss ☐ Right eye ☐ Left eye
2. Spontaneously reported distortion ☐ Right eye ☐ Left eye
3. Onset of scotoma (or blurred spot) in central vision ☐ Right eye ☐ Left eye
4. Macular drusen (either eye) ☐ Right eye ☐ Left eye
5. Macular haemorrhage (preretinal, retinal, subretinal) ☐ Right eye ☐ Left eye
6. Subretinal fluid ☐ Right eye ☐ Left eye
7. Exudate ☐ Right eye ☐ Left eye

Additional Commments

We care

Dec 2022

The completed form must be sent via NHSmail to the designated mailbox only: dbth.wetamd@nhs.net

Adapted from: The Royal College of Ophthalmologists