MACULAR SERVICE RAPID ACCESS REFERRAL FORM

OPTOMETRIST

Name:
GOS Personal code:
Practice address:

GENERAL MEDICAL PRACTITIONER

Name:
GP Practice Address:

Signature: **Date:**

PATIENT DETAILS

Title: (Please Select) **Forename (s):** **Surname:**

Health &Care No: **Date of birth:**

Address:

Post code: **Contact Tel No(s):**

Date of Referral: **Driver: Yes ◯ No ◯**

Suspected condition: wAMD ◯ RVO ◯ DMO ◯ **Affected Eye: RIGHT ☐ LEFT ☐**
(MUST COMPLETE – MARK ONE OPTION ONLY WITH AN X)

Refraction and IOP Details

	Unaided vision	Sph	Cyl	Axis	Best Corrected VA (must be 6/96 or better in affected eye)	Add	Near VA	Previous VA (if known state date)	IOP (state method and time)
R									
L									

Referral Guidelines (one answer must be YES and please tick the correct)

Past MACULAR history in either eye: YES ◯ NO ◯ **If Yes: RIGHT EYE ☐ LEFT EYE ☐**

Duration of Symptomatic Visual Loss:_____

1. Symptomatic Visual Loss **YES ◯** **NO ◯**

2. Spontaneously reported distortion **YES ◯** **NO ◯**

3. Onset of Scotoma (or blurred spot) in central vision **YES ◯** **NO ◯**

4. Macular Drusen (either eye) **RIGHT ☐** **LEFT ☐**

In the AFFECTED EYE ONLY, presence of (please tick the correct box):

5. Macular Haemorrhage **RIGHT ☐** **LEFT ☐**

6. Subretinal fluid **RIGHT ☐** **LEFT ☐**

7. Exudate **RIGHT ☐** **LEFT ☐**

Other Significant Medical History: Diabetes YES ◯ NO ◯ Hypertension YES ☐ NO ☐ Other ☐
(please specify):

Please send this referral to:
BHSCT – Macular Service, Fairview Buildings, Mater Hospital, Crumlin Road, Belfast BT 14 6AB
WHSCT – Ophthalmology Macular Service, Clinic 6, Altnagelvin Hospital, Glenshane Road, Londonderry BT47 6SB