

EMERGENCY MACULA (EMAC) SERVICE OPTOMETRIST REFERRAL FORM
Email: mft.macular@nhs.net

Patient Name: _____

Patient Date of Birth: _____

Address: _____

Urgent Contact no. _____

Optometrist Name: _____

GOC number: _____

Practice phone number: _____

Practice Address: _____

Clinical Features

History and Symptoms

Best Corrected Visual Acuity Right _____ Left _____

Clinical Features in affected eye

Macular Haemorrhage	Right <input type="checkbox"/>	Left <input type="checkbox"/>
Retinal Oedema	Right <input type="checkbox"/>	Left <input type="checkbox"/>
Exudates	Right <input type="checkbox"/>	Left <input type="checkbox"/>

3. Additional Comments:

Please confirm which disease you are suspecting based on your clinical examination:

- ☐ Wet AMD
- ☐ Myopic CNV
- ☐ Central/Branch Retinal Vein Occlusion **with macula oedema**

Signature.....

Date of referral.....