Manchester University NHS Foundation Trust

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 ☐	Left ☐
Retinal Oedema	Right ☐	Left ☐
Exudates	Right ☐	Left ☐

3. Additional Comments:

_____

_____

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

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

2 ☐ Unknown / Diagnosis not possible clinically but possibly urgent pathology

Patients who you feel may require urgent treatment with intravitreal injection therapy.

Signature…… Date of referral……