Manchester University
NHS Foundation Trust

EMERGENCY MACULA (EMAC) SERVICE OPTOMETRIST REFERRAL FORM

Tel: 0161 7013419 Email: mft.macular@nhs.net

Patient Name:___________________________

Patient Date of Birth:____________________

Address:_______________________________

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Urgent Contact no. _____________________

Optometrist Name:_____________________

GOC number: ___________________

Practice phone number: _________________

Practice Address:

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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:

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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………………..