Age Related Macular Degeneration (AMD)

Referral And Transfer Of Care Form - **Fax to : 01625 440 002**

If you do not receive a faxed confirmation within 1 working day please phone us on 01625 511 359 and leave a message to ensure that your referral has been received.

Appointment and treatment offered within two weeks of referral

We accept patients both newly diagnosed and currently under treatment

eyecare medical

Macular Disease Specialists

Macular Society Service of the Year Award Winners

Please tick the preferred fast-track Eyecare Medical community clinic					
	Vision House, Gunco Lane, Macclesfield, SK11 7JL		**Watling Street Medical Cntr, Northwich, CW9 5EX**		**The Orchard Surgery, Bromborough, CH62 7EU**

Please tick the preferred treatment funding option			
NHS	**NHS Funding** Available for patients in: East Cheshire, South Cheshire, West Cheshire, Vale Royal, Derbyshire, North Staffordshire and Stoke.	☐	**Private insurance/self pay** Please document the medical insurance provider if known. ☐

Patient Details			
Last Name		Address	
First Name			
DOB			
Phone		Postcode	
Referrer Details			
Name		Address	
Organisation			
Phone			
Fax		Postcode	
GP Details			
GP Name		GP Practice	

Ophthalmic History (tick affected eye as appropriate)					
Previous AMD	R	L	Myopia	R	L
Current Provider (if applicable)					
Other					
Presenting Symptoms (tick affected eye as appropriate)					
Visual Acuity	R	L	Duration of symptoms		
Distortion	R	L	Scotoma	R	L
Subretinal fluid	R	L	Macular haemorrhage	R	L
Note					

Signature of Referrer		Date	