WESTERN TRUST OPHTHALMOLOGY DEPARTMENT

WET AMD DIRECT REFERRAL FORM

REFERRING CLINICIAN DETAILS: **Referral Date:**

Name:

Address:

Tel no:

PATIENT DETAILS:

HOSPITAL / H&C NO:

NAME:

ADDRESS:

DOB:

TEL NO:

GP NAME:

GP ADDRESS:

CLINICAL INFORMATION:

Affected eye (Please circle)	R	L

	R	L
VA		
REFRACTION		

DURATION OF SYMPTOMS:

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PAST HISTORY IN EITHER EYE:

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……
……

OTHER INFORMATION:

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……
……

FORWARD TO : Ophthalmology Macular Service, C/O Outpatients Dept – Clinic 6, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB FAX: 02871 611418

***PLEASE ATTACH MEDICAL HISTORY**