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:_____

_____

_____

Urgent Contact no. _____

Optometrist Name:_____

Optometrist Number:_____

Practice Address:

_____

_____

Clinical Features

1. Best Corrected Visual Acuity Right _____ Left _____

2. Clinical Features in affected eye

Amsler distortion	Right ☐	Left ☐
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 Retinal Vein Occlusion / haemorrhagic branch retinal vein occlusion

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

3. ☐ Branch Retinal Vein Occlusion (without haemorrhage involving centre of fovea)

☐ Diabetic Macular Oedema ☐ Central Serous Retinopathy

☐ Vitreomacular Traction ☐ Macular Hole ☐ Epiretinal membrane

Please note, only patients in group 1 above require urgent referral or if group 2 i.e. you are uncertain of the diagnosis which may be urgent and patient needs OCT to confirm. Patients in group 3 if you are confident of the diagnosis may be referred via GP as normal.

Signature…… Date of referral……..