

THE ALFRED REFERRAL GUIDELINES: OPHTHALMOLOGY

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Referral priority guide

<p>Immediate</p> <p>Trauma not able to be treated conservatively:</p> <ul style="list-style-type: none"> ▪ Surgical trauma to the lids, orbit, ocular structures ▪ Penetrating eye injuries ▪ Retained intraocular foreign bodies ▪ Hyphema ▪ Chemical burns <p>Painful red eye with significant loss of vision:</p> <ul style="list-style-type: none"> ▪ Corneal ulcer ▪ Acute glaucoma ▪ Iritis <p>Infective conditions:</p> <ul style="list-style-type: none"> ▪ Herpes zoster/simplex ▪ Acute dacryocystitis <p>Sudden severe vision loss:</p> <ul style="list-style-type: none"> ▪ Ischemic ocular conditions, eg temporal arteritis ▪ Optic neuritis ▪ Retinal detachments <p>Painful diplopia</p>	<p>Phone the Ophthalmology Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.</p>
<p>Urgent</p> <ul style="list-style-type: none"> ▪ Sudden visual loss ▪ Neurological conditions threatening permanent damage if treatment delayed ▪ Diabetic conditions with sudden or severe loss of vision ▪ Painful red eye with loss of vision ▪ Traumatic conditions: ▪ Progressive/invasive cancers ▪ Infective conditions: 	<p>Urgent cases must be discussed with the Ophthalmology Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.</p> <p>Likely to receive an appointment within 1-2 weeks.</p>
<p>Soon</p>	<p>Likely to receive an appointment within 2-6 weeks.</p>
<p>Intermediate</p>	<p>Likely to receive an appointment within 6-12 weeks.</p>
<p>Non-urgent</p>	<p>Appointment may be delayed.</p>
<p>Not seen</p>	<p>The following conditions are not routinely seen at the Alfred:</p> <ul style="list-style-type: none"> • Adult refractive conditions alone, without co-morbidity • Minor cosmetic abnormalities without any other pathology • Presbyopia without co-morbidity • Routine screening eg diabetes, FH glaucoma, drug toxicity, HA • Children under 16 years of age

Please note: The times to assessment may vary depending on size and staffing of the hospital department. If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Ophthalmology Registrar on call on 9076 2000.

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Cataracts

Evaluation	Management	Referral Guidelines
<ul style="list-style-type: none"> ▪ BCVA (with distance glasses) ▪ Last optometric assessment ▪ Level of visual impairment (recreational, educational, occupational, driving) ▪ Social circumstances ▪ Whether first or second eye 	<ul style="list-style-type: none"> ▪ If appropriate, optometric assessment ▪ Consider appropriate domiciliary aids <p>If vision in each eye is 6/12 or better review in six months (unless occupational factors override, eg passenger service license)</p>	<ul style="list-style-type: none"> ▪ Ideally a recent optometric assessment (within six months) done prior to referral <p>If vision in either eye is worse than 6/12 – PRIORITY 4</p> <p style="text-align: right;">Return to contents page</p>

Diabetes

Evaluation	Management	Referral Guidelines
<ul style="list-style-type: none"> ▪ Screening (IDDM/NIDDM) ▪ Duration/new case ▪ Drug regime ▪ Previous ocular examination ▪ Systemic diabetes disease ▪ Risk factors (smoking, hypertension, pregnancy, poor circulation) 	<p>Asymptomatic NIDDM's – screening by GP, local ophthalmologist or optometrist</p>	<p>New and established NIDDM:</p> <ul style="list-style-type: none"> ▪ New IDDM at 5 years ▪ Prompt referral for the following cases: progressive /intermittent LOV, pregnancy, multiple risk factors – PRIORITY 1-3 <p style="text-align: right;">Return to contents page</p>

Diplopia

Evaluation	Management	Referral Guidelines
Acute, painful diplopia		
		<p>Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre</p> <p style="text-align: right;">Return to contents page</p>
Acute, painless diplopia		
		<p>Refer urgently – PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p>

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Eye infections / inflammations

Evaluation	Management	Referral Guidelines
Viral / bacterial conjunctivitis with discharge		
<ul style="list-style-type: none"> ▪ Reduced vision ▪ Discharge (purulent or watery) ▪ Photophobia (with or without pain) ▪ Itch/irritation ▪ Unilateral/bilateral ▪ Fluorescein staining (yes/no) ▪ Duration/frequency ▪ Current topical therapy ▪ Contact lens wearer (hard/soft) ▪ Ocular pain 	<p>Appropriate broad-spectrum topical antibiotic (eg Chloramphenicol). If unresponsive after four days, re-evaluate and refer if appropriate</p>	<p>If:</p> <ul style="list-style-type: none"> ▪ Red eye with reduced vision; ▪ Suspected iritis; ▪ Suspected corneal ulcer; ▪ Suspected herpes simplex; infections; or ▪ Herpes zoster ophthalmicus with eye involvement, <p>refer immediately – phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre</p> <p style="text-align: right;">Return to contents page</p>
Acute dacrocystitis		
	<p>One full course of broad spectrum systemic antibiotic (eg Augmentin, Flucloxacillin) and refer</p>	<p>Refer immediately – Phone Ophthalmology registrar on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre, or PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p>
Drug allergy		
	<p>Cessation of drug, conservative treatment, eg lubricants, topical decongestants, mast cell stabilisers and removal of allergies</p>	<p>If unresponsive and severe – refer PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p>
Vernal catarrh		
<p>Vernal catarrh is severe conjunctivitis, often in younger age group, characterised by severe itch, stringy mucoid discharge and typical thickened swollen "leathery" inferior fornix +/- cobblestone papillae, upper lid.</p> <p>NOTE: The discharge is quite characteristic for this condition</p>		<p>Refer PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p>
Contact lens wearer		
	<ul style="list-style-type: none"> ▪ Avoid secondary topical drug therapy ▪ Review management by patient of contact lens 	<p>If sub-acute, optometric management preferred. If acute, or associated ulcer– refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre, or PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p>

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Eyelids / malposition

Evaluation

- Discharge (purulent or watery)
- Photophobia (with or without pain)
- Itch/irritation
- Unilateral/bilateral
- Duration/frequency
- Current topical therapy
- Contact lens wearer (hard/soft)
- Acutely inflamed eyelid
- Swelling lid and chymosis

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Diagnosis	Management	Referral Guidelines
Blepharitis without co - morbidity	Lid scrub regime with/without AB	Severe and persistent blepharitis with secondary ocular and lid changes: Refer PRIORITY 4 Return to contents page
Trichiasis	Epilation – manual or otherwise	If unresponsive/recurrent – refer PRIORITY 4 Return to contents page
Ectropion		Refer if severe symptoms – PRIORITY 2-3 Return to contents page
Entropion	Check for corneal damage with fluorescein.	Prompt referral – PRIORITY 1-3 Return to contents page
Peri-orbital cellulitis		Prompt referral – immediate for children– PRIORITY 1 for adults NB Children under 16 years of age are not seen at The Alfred – refer immediately to appropriate hospital Return to contents page
Acute chalazion / stye	Systemic AB (eg Augmentin) +/- cyst drainage	Chronic recurrent chalazia: Removal/refer – PRIORITY 4 Return to contents page

Acute glaucomas

Evaluation	Management	Referral Guidelines
Family history	Encourage all patients to have glaucoma screened by optometrist at age 45.	If confirmed open angle glaucoma, refer PRIORITY 4 Return to contents page
<ul style="list-style-type: none"> ▪ Red pain ▪ LOV ▪ Photophobia ▪ Steamy cornea ▪ Hard eye 		Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page
Usually asymptomatic		Suspicion of glaucoma, eg optometrist evidence – PRIORITY 1 – otherwise PRIORITY 4 Return to contents page

Intra-ocular foreign bodies

Evaluation	Management	Referral Guidelines
<ul style="list-style-type: none"> ▪ Site of entry ▪ X-ray ▪ History ▪ VA ▪ Attendant ocular signs 	Cover eye (systemic AB only after consultation)	<ul style="list-style-type: none"> ▪ Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page

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Loss of vision (non-cataract)

Evaluation

<p>Severe loss of vision:</p> <ul style="list-style-type: none"> - speed of onset - pain - systemic disease <ul style="list-style-type: none"> ▪ Afferent pupil defect ▪ Unilateral or bilateral ▪ Fundus examination (often normal) <p>NB. Dilate pupils to allow fundal examination only after exclusion of afferent pupil defect</p>	<p>Transient loss of vision:</p> <ul style="list-style-type: none"> ▪ TIAs: fundus exam, bruit <p>NB. Dilate pupils to allow fundal examination only after exclusion of afferent pupil defect</p> <p style="text-align: right;">Return to contents page</p>
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Diagnosis	Evaluation	Referral Guidelines
Arterial Occlusions	<ul style="list-style-type: none"> ▪ Suspected giant cell arteritis 	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page
Retinal Detachments		Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
Floater/Flashes		Refer appropriate specialist – PRIORITY 1 Return to contents page
Optic Neuritis		Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page
Optic Nerve Swelling or Pathology	Unilateral	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page
	Bilateral	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page

Ophthalmological headache

Evaluation	Management	Referral Guidelines
Tension headache		
<ul style="list-style-type: none"> ▪ No neurological signs/symptoms ▪ Normal Visual acuity (VA) 	No need for routine ophthalmic assessment	Return to contents page

Vascular

Migrainous cluster with visual symptoms	No need for routine referral unless suspect associated ocular pathology	Return to contents page
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Raised intracranial pressure

+/- Neurological signs/symptoms		Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Return to contents page
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Giant cell arteritis and other vascular disease

Immediate ESR	Immediate discussion with Ophthalmologist for acute sight threatening giant cell arteritis is mandatory	<ul style="list-style-type: none"> ▪ Immediate referral is mandatory if associated loss of vision – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre ▪ Urgent referral if pathology is suspected with confirmatory signs/symptoms and raised ESR – PRIORITY 1 <p style="text-align: right;">Return to contents page</p>
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Ocular pathology

Headaches associated with ocular signs and symptoms (red eye, epiphora, proptosis, etc)		<ul style="list-style-type: none"> ▪ Immediate referral if associated loss of vision or progressive loss of function (diplopia) – Phone Ophthalmology registrar and/or send to
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		<p>The Alfred Emergency & Trauma Centre</p> <ul style="list-style-type: none"> ▪ Urgent referral if no loss of vision or no progressive loss of function (as above)– PRIORITY1 <p>Return to contents page</p>
Accommodative / asthenopic (eye strain)		
Confirm absence of neurological vascular, tension headaches, etc		<ul style="list-style-type: none"> ▪ For asthenopic symptoms, suggest referral initially to optometrist for initial assessment <p>Return to contents page</p>

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Orbital pain

Evaluation	Management	Referral Guidelines
Proptosis		
<ul style="list-style-type: none"> ▪ Acute, chronic, endocrine ▪ Painful ▪ Masses ▪ Ocular movement 		<ul style="list-style-type: none"> ▪ Acute proptosis - Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre ▪ Refer PRIORITY 1-3 depending on time frame and severity <p style="text-align: right;">Return to contents page</p>

Trauma

Evaluation	Management	Referral Guidelines
Adnexal (lids)		
Functional anatomical integrity	Antibiotic ointment, pad	Refer as appropriate; eg all full thickness lacerations of the upper lid, suspected canalicular disruption, levator disruption –refer immediately – phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
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Orbit

Diplopia +/- x-ray The Alfred Radiology request form	Antibiotics as appropriate	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
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Penetrating non-magnetic metal / non-metal, velocity

	No nose blowing	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
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Chemical

<ul style="list-style-type: none"> ▪ History (acid, alkali, other) ▪ Phototoxic burns/UV burns 	Must be excluded in all ocular traumas. Contact poisons centre.	Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
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Blunt

<ul style="list-style-type: none"> ▪ Hyphema ▪ Traumatic mydriasis ▪ LOV 	<ul style="list-style-type: none"> ▪ Topical anaesthesia ▪ Copious irrigation, maintain for 15 minutes 	<ul style="list-style-type: none"> ▪ Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
Return to contents page		

External foreign bodies

Foreign bodies on ocular surface	<ul style="list-style-type: none"> ▪ Removal of solid particles ▪ Topical AB 	Refer if in doubt
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Corneal

	<ul style="list-style-type: none"> ▪ Dark glasses ▪ Site specific: within pupil zone ▪ If outside pupil zone, removal under LA 	<ul style="list-style-type: none"> ▪ Refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre ▪ Refer if pain persists
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Subtarsal - occult

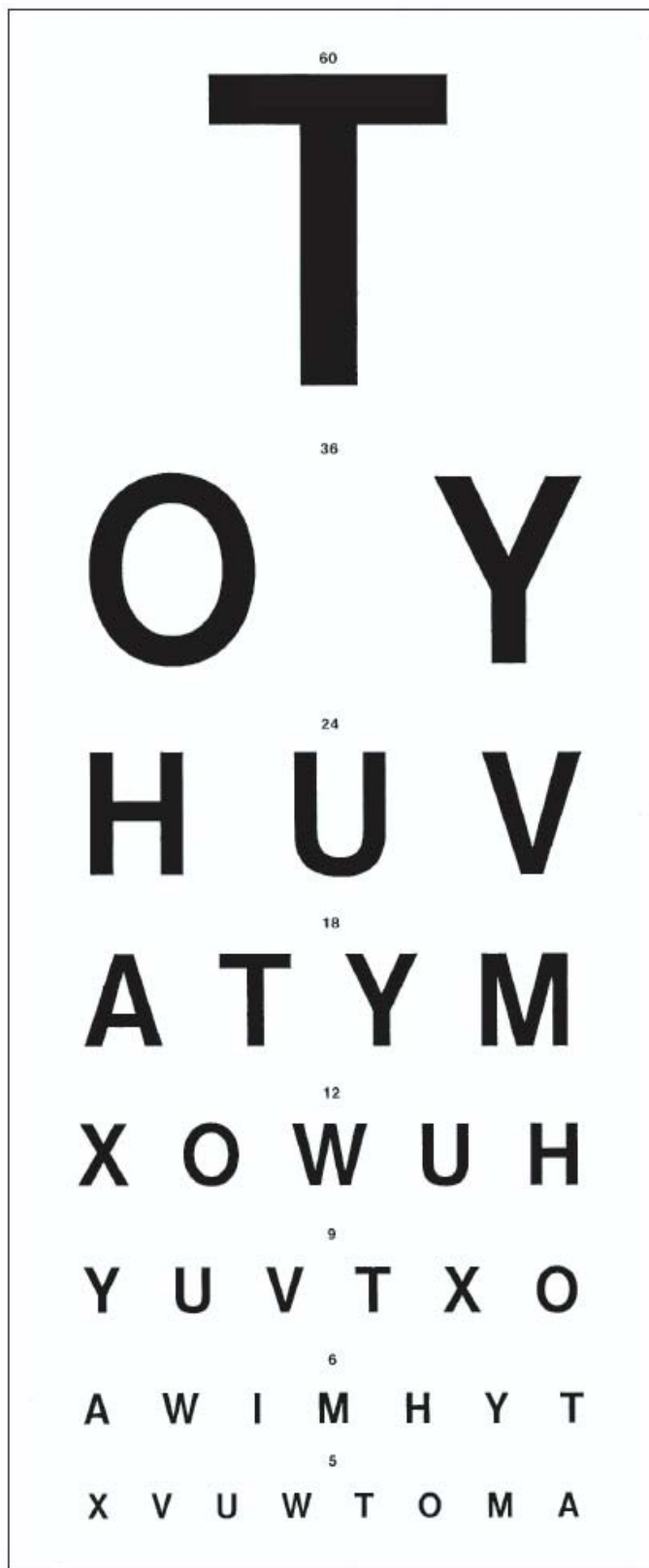
	<ul style="list-style-type: none"> ▪ Remove under LA ▪ Adjunctive fluorescein staining may help localisation. 	<ul style="list-style-type: none"> ▪ If difficult/incomplete – refer immediately – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre, or PRIORITY 1
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Watery eye

Diagnosis	Evaluation	Referral Guidelines
Acquired Adult	<ul style="list-style-type: none"> ▪ See if fluorescein dye inserted in the eye can be blown from the nose after five minutes 	<ul style="list-style-type: none"> ▪ Refer PRIORITY 4 ▪ Refer all acquired immediately – Phone

- | | | |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none">▪ Photophobia/redness▪ Hazy and enlarged cornea▪ Frank suppuration▪ Excessive lacrimation▪ Inadequate drainage – lid/punctal position, history of trauma, nasal pathology | <p>Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre, or PRIORITY 1</p> <p style="text-align: right;">Return to contents page</p> |
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Snellen Visual Acuity Chart... Test from 3 Metres



NOTES:

(If patient wears glasses, keep them on, or, if not available, a pinhole through a dark piece of paper will suffice).

Visual Acuity

Each eye is tested separately.

At 3 metres, the readings correspond to the acuities listed to the right of the chart.

If the patient cannot read the 6/60, the chart may be brought closer, to 1m, then 30cm (note this).

.....6/60

HM: Hand Movements vision.

If the patient can't see 6/60, the above can be done for hand movements, starting from 3m.

LP: Light Perception only.

When patient doesn't see HM, light is shone from ~30cm in each eye, ensuring one eye is well covered.

.....6/36

NPL: No Perception of Light

As implied, there is no vision at all.

RAPD

Relative Afferent Pupillary Defect
aka. Marcus-Gunn Pupils

This refers to a discrepancy in the pupil light responses between the two eyes in the 'swinging light test'. Shining the torch in one eye causes constriction of both pupils, then shining it in the effected eye causes dilation in both pupils.

If so, there is said to be an RAPD in the abnormally responding eye.

.....6/24

.....6/18

.....6/12

A normal pupil light response would be equal constriction in both pupils as the torch is shone in each eye alternately.

.....6/9

Eye Movements

Test movements in an 'H' pattern, in a range of 45 degrees.

Note the directions which cause the most diplopia, and also any obvious restriction or asymmetry in movements.

.....6/6

.....6/5

