AlfredHealth

REFERRAL GUIDELINES: OPHTHALMOLOGY

Essential Referral Content

Demographic

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements
- Medicare number

Clinical

- Reason for referral
- Duration of symptoms
- Relevant pathology & imaging reports
- Past medical history
- Current medications

Ophthalmology Referral Form is available to print and fax to the Outpatient Department on 9076 6938

Exclusion Criteria

The following conditions are not routinely seen at the Alfred:

- Adult refractive conditions alone, without co-morbidity
- Minor ocular abnormalities without any other pathology (eg blepharitis & dry eyes)
- Presbyopia without co-morbidity
- Routine screening e.g. diabetes, family history of glaucoma, drug toxicity
- Patients who are being treated for the same condition at another Victorian public hospital
- Patients who are under the care of a private ophthalmologist
- Standard ocular surface infections (eg conjunctivitis)
- Surgical retinal conditions (eg retinal detachment, macular holes) - refer to Royal Victorian Eye and Ear or Royal Melbourne Hospital for retinal surgical services
- Children under 18 years of age are not seen at the Alfred

REFERRAL PROCESS: OPHTHALMOLOGY

STEP 1

You will be notified when your referral is received by outpatients.

Essential referral content will be checked and you may be contacted for further information if required.

STEP 2

The referral is triaged by the specialist unit according to clinical urgency.

This determines how long the patient will wait for an appointment.

STEP 3

Patients with **urgent** conditions are scheduled to be seen within 30 days.
Patients with **routine** conditions are given the next available appointment according to clinical need.
Both the referrer and patient are notified.

Some clinics offer an MBS-billed service. **There is no out of pocket expense to the patient.** MBS-billed services require a current referral to a named specialist– please provide your patient with a **12 month referral addressed to the specialist of your choice.**
Further information regarding the specialists attending the Ophthalmology clinic is available here.
Please note that your patient may be seen by another specialist in that clinic, in order to expedite their treatment.

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.

The Alfred gratefully acknowledges the assistance of the Canterbury and District Health Board in New Zealand in developing these guidelines.
They are intended as a guide only and have been developed in conjunction with the Heads of Unit of The Alfred.

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REFERRAL PRIORITY: OPHTHALMOLOGY

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

IMMEDIATE **Direct to the Emergency & Trauma Centre**	URGENT **Appointment timeframe within 30 days**	ROUTINE **Appointment timeframe greater than 30 days depending on clinical need**
Trauma not able to be treated conservatively: • Surgical trauma to the lids, orbit, ocular structures • Penetrating eye injuries • Retained intraocular foreign bodies • Hyphema • Chemical burns **Painful red eye with significant loss of vision:** • Corneal ulcer • Acute glaucoma • Iritis **Infective conditions:** • Acute dacryocystitis **Sudden severe vision loss:** • Ischemic ocular conditions, eg temporal arteritis • Optic neuritis • Retinal detachments **Painful diplopia**	• Neurological conditions threatening permanent damage if treatment delayed • Diabetic conditions with sudden or severe loss of vision • Traumatic conditions able to be treated conservatively • Progressive/invasive cancers • Herpes zoster and herpes simplex	
Phone the Ophthalmology Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.	Urgent cases must be discussed with the Ophthalmology Registrar on call to obtain appropriate prioritisation and a referral faxed to 9076 6938.	Fax referral to 9076 6938

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.

Referral Guideline Contents

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- Cataracts
- Diabetes
- Diplopia
  - Acute, painful
  - Acute, painless
- Eye infections / inflammations:
  - Viral / bacterial conjunctivitis with discharge
  - Acute dacryocystitis
  - Drug allergy
  - Vernal catarrh
  - Contact lens wearer
- Eyelid disorders / malposition
- Glaucoma—Acute
- Headache
  - Tension headache
  - Vascular
  - Raised intracranial pressure
- Headache cont.
  - Giant cell arteritis and other vascular disease
  - Ocular pathology
  - Accommodative / asthenopic (eye strain)
- Intra Ocular Foreign Bodies
- Loss of vision (non-cataract)
- Orbital pain
  - Proptosis
- Trauma
  - Adnexal (lids)
  - Orbit
  - Penetrating non-magnetic metal / non-metal, velocity
  - Chemical
  - Blunt trauma
  - External foreign bodies
  - Corneal
  - Subtarsal (occult)
- Watery eye

CATARACTS

Evaluation	Management	Referral Guidelines
BCVA (with distance glasses) Last optometric assessment Level of visual impairment (recreational, educational, occupational, driving) Social circumstances Whether first or second eye	If appropriate, optometric assessment Consider appropriate domiciliary aids If vision in each eye is 6/12 or better review in six months (unless occupational factors override, e.g. passenger service license)	Ideally a recent optometric assessment (within six months) done prior to referral If vision in either eye is worse than 6/12 Refer - Routine

DIABETES

Evaluation	Management	Referral Guidelines
Screening (IDDM/NIDDM) Duration/new case Drug regime Previous ocular examination Systemic diabetes disease Risk factors (smoking, hypertension, pregnancy, poor circulation)	Asymptomatic diabetics are not routinely seen at the Alfred – screening by GP, local ophthalmologist or optometrist	Prompt referral for the following cases: progressive /intermittent LOV, pregnancy, multiple risk factors Refer - Urgent or Routine according to clinical indication.

ACUTE DIPLOPIA (Painful/Painless)

Evaluation	Management	Referral Guidelines
Acute - Painful Diplopia		Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
Acute - Painless Diplopia		Refer - Urgent

EYE INFECTIONS / INFLAMMATIONS:

Viral/Bacterial Conjunctivitis with Discharge

Evaluation	Management	Referral Guidelines
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	Appropriate broad-spectrum topical antibiotic (eg Chloramphenicol). If unresponsive after four days, re-evaluate and refer if appropriate	Refer IMMEDIATELY If: • Red eye with reduced vision; • Suspected iritis; • Suspected corneal ulcer; • Suspected herpes simplex; infections; or • Herpes zoster ophthalmicus with eye involvement, Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Acute Dacryocystitis

Evaluation	Management	Referral Guidelines
	One full course of broad spectrum systemic antibiotic (eg Augmentin, Flucloxacillin) and refer	Refer IMMEDIATELY – Phone Ophthalmology registrar on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre, or refer - Urgent

Drug Allergy

Evaluation	Management	Referral Guidelines
	Cessation of drug, conservative treatment, eg lubricants, topical decongestants, mast cell stabilisers and removal of allergies	If unresponsive and severe, refer - Urgent

Vernal Catarrh

Evaluation	Management	Referral Guidelines
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. **NOTE**: The discharge is quite characteristic for this condition		Refer urgently if corneal ulceration is present

Contact lens wearer

Evaluation	Management	Referral Guidelines
	Avoid secondary topical drug therapy Review management by patient of contact lens	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 refer - Urgent

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EYELID DISORDERS/MALPOSITION

Evaluation	Diagnosis	Management	Referral Guidelines
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 Lid swelling and chemosis	**Blepharitis without co - morbidity**	Lid scrub regime with/without AB	Not routinely seen at the Alfred
	Trichiasis	Epilation – manual or otherwise	If unresponsive/recurrent , refer - Routine
	Ectropion		Refer if severe symptoms – Routine
	Entropion	Check for corneal damage with fluorescein.	Prompt referral - Urgent or Routine according to clinical indication
	Peri-orbital cellulitis		Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Please note: children under 16 years are not routinely seen at The Alfred
	Acute chalazion / stye	Systemic AB (eg Augmentin) +/- cyst drainage	Not routinely seen at the Alfred

ACUTE GLAUCOMA

Evaluation	Management	Referral Guidelines
Family history	Encourage all patients to have glaucoma screened by optometrist at age 45.	If confirmed open angle glaucoma, refer - Routine
Red pain Loss of vision Photophobia Steamy cornea Hard eye		If suspected angle closure refer IMMEDIATELY – phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
Usually asymptomatic		If optometrist evidence, refer -Urgent ; if asymptomatic suspicion of glaucoma otherwise refer – Routine

HEADACHE:
Tension Headache

Evaluation	Management	Referral Guidelines
No neurological signs/symptoms Normal Visual acuity (VA)		No need for routine ophthalmic assessment

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Vascular

Evaluation	Management	Referral Guidelines
Migrainous cluster with visual symptoms		No need for routine referral unless suspect associated ocular pathology

Raised Intracranial Pressure

Evaluation	Management	Referral Guidelines
+/- Neurological signs/symptoms		Refer IMMEDIATELY – Phone Neurology or Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Giant cell Arteritis/Other Vascular disease

Evaluation	Management	Referral Guidelines
Immediate ESR	Immediate discussion with Ophthalmologist for acute sight threatening giant cell arteritis is mandatory	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

Headache with Ocular pathology

Evaluation	Management	Referral Guidelines
Headaches associated with ocular signs and symptoms (red eye, epiphora, proptosis, etc.)		IMMEDIATE referral if associated loss of vision or progressive loss of function (diplopia) – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre Urgent referral if no loss of vision or no progressive loss of function (as above)

Accommodative / Asthenopic

Evaluation	Management	Referral Guidelines
Confirm absence of neurological vascular, tension headaches, etc		Not routinely seen at the Alfred. For asthenopic symptoms, suggest referral to optometrist for assessment.

INTRA OCULAR FOREIGN BODIES

Evaluation	Management	Referral Guidelines
Site of entry X-ray History Visual acuity Attendant ocular signs	Remove foreign body if superficial and easy to remove. Cover eye (systemic AB only after consultation)	Refer IMMEDIATELY if: - suspicious nature of injury - difficult to remove foreign body - visual loss - suspected penetration Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

LOSS OF VISION (Non cataract)

Evaluation	Diagnosis	Management	Referral Guidelines
Severe loss of vision: - speed of onset - pain - systemic disease Afferent pupil defect Unilateral or bilateral Fundus examination (often normal) NB. Dilate pupils to allow fundal examination **only after** exclusion of afferent pupil defect	**Arterial Occlusions**	Suspected giant cell arteritis	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
	Retinal Detachments		Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
	Floaters/Flashes		Refer appropriate specialist – Urgent
Transient loss of vision: TIAs: fundus exam, bruit NB. Dilate pupils to allow fundal examination **only after** exclusion of afferent pupil defect	**Optic Neuritis**		Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
	Optic Nerve Swelling or Pathology	Unilateral	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre
		Bilateral	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

ORBITAL PAIN - Proptosis

Evaluation	Management	Referral Guidelines
Acute, chronic, endocrine Painful Masses Ocular movement		Acute proptosis - refer IMMEDIATELY – phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre. If not acute, refer - Urgent or Routine depending on time frame and severity

TRAUMA:
Adnexal (lids)

Evaluation	Management	Referral Guidelines
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

Orbital trauma

Evaluation	Management	Referral Guidelines
Diplopia +/- x-ray	Antibiotics as appropriate	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Penetrating non magnetic metal/non metal, velocity

Evaluation	Management	Referral Guidelines
	No nose blowing	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Chemical trauma

Evaluation	Management	Referral Guidelines
History (acid, alkali, other) Phototoxic burns/UV burns	Prolonged washout immediately with tap water and with local anaesthetic if readily available. Must be excluded in all ocular traumas. Contact poisons centre.	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Blunt trauma

Evaluation	Management	Referral Guidelines
Hyphema Traumatic mydriasis Loss of vision	Topical anaesthesia Copious irrigation, maintain for 15 minutes	Refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

External foreign bodies

Evaluation	Management	Referral Guidelines
Foreign bodies on ocular surface	Remove foreign body if superficial and easy to remove. Cover eye and topical AB	Refer IMMEDIATELY if: - suspicious nature of injury - difficult to remove foreign body - visual loss - suspected penetration Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

Corneal trauma

Evaluation	Management	Referral Guidelines
	Dark glasses Site specific: within pupil zone If outside pupil zone, removal under LA	If penetrating trauma or suspected infection, refer IMMEDIATELY – phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre. Superficial corneal abrasions or flash burns can be managed conservatively by GP.

Subtarsal (occult)

Evaluation	Management	Referral Guidelines
	Remove under LA Adjunctive fluorescein staining may help localisation.	If difficult/incomplete – refer IMMEDIATELY – Phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre

WATERY EYE

Evaluation	Management	Referral Guidelines
Acquired Adult	Photophobia/redness Hazy and enlarged cornea Frank suppuration Excessive lacrimation Inadequate drainage – lid/punctal position, history of trauma, nasal pathology	If acutely acquired, severe pain or visual loss, refer IMMEDIATELY—phone Ophthalmology registrar and/or send to The Alfred Emergency & Trauma Centre If non-acute, refer—Routine