Ophthalmology

Referral Guidance

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www.evolutio-uk.com

About Evolutio

Evolutio are one of the leading facilitators of community ophthalmology in England, utilising continuous innovation to drive up standards of patient care.

The Evolutio referral support service allows us, as part of our wider system, to plan, direct and optimise the most appropriate services for patients, whilst reducing the variability in the referral process and improving patient outcomes & experiences.

Our services provide the quality framework to accept, triage, assess, diagnose, treat and manage more patients in the community under the supervision of a consultant ophthalmologist, enabling better utilisation of clinical resources across the local healthcare economy. Understanding the local health needs is a fundamental principle of our services and we work collaboratively with our clients and key stakeholders to offer a number of benefits including:

- Reduction in false positive referrals
- Improved appropriateness of care (right care, right place, right time)
- Convenient and accessible care, often closer to home
- Introduction and utilisation of innovative technologies
- Interoperability between community optometrists and primary/secondary care services by providing governance and a effective framework
- Virtual OCT clinics and home monitoring apps for smartphones and tablets

Each CCG has unique condition-specific policies and service providers; please consult our website for the relevant links within our contracted areas: **www.evolutio-uk.com**

About this guide

This document was developed by Evolutio's clinical team in conjunction with consultant ophthalmologists from Frimley Health Foundation Trust (Surrey). It provides guidance on the most appropriate provider, clinic type and urgency for a range of conditions which are commonly encountered by optometrist and GP referrers.

We welcome ongoing comments and input into this guide from clinicians and intend to produce regular updates and revisions:

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Helpline for referrers **within our contracted areas**:

Referral Queries T: **0203 780 7860**
Clinical Queries: T**: 0333 015 6677**

How to use this guide

Due to local variations, specific guidance will vary between CCGs and consultants therefore referrers must always use their clinical judgment and consider national and local guidelines when referring. Clinicians should be aware of local pathways and associated inclusion/exclusion criteria.

Ophthalmology is subdivided into several sub-specialities/clinic types which can be found on the following pages:

Page	Title	Contents
4	**Oculoplastics/Orbits/Lacrimal**	Eyelid lumps, ptosis, en/ectropion, exophthalmos, epiphora, prosthetics
5	**External Eye Disease & Cornea**	Anterior eye (e.g. sclera, conjunctiva, dry eye) including non-oculoplastic lid conditions and corneal conditions
6	**Glaucoma**	Raised IOP, shallow A/C angles and other glaucomatous signs
7	**Other Medical Retina (OMR)**	Macula, medical retina, pigmented retinal lesions, choroid
	Wet AMD	Likely wet AMD - often local fast-track policy
	Diabetic Medical Retina	Diabetic retinopathy/maculopathy
8	**Vitreoretinal**	RD/hole/tear, PVD, ERM, VMT, lattice [tends to be surgical]
9	**Not Otherwise Specified (NOS)**	General ophthalmology (all other conditions), multiple conditions
9	**Low Vision**	Low vision aids
10	**Neuro-Ophthalmology**	Pupils, disc pathology (non-glaucomatous), neurological field defects and nerve palsies
11	**Squint / Ocular Motility**	Known/suspected squint or motility defect
	Orthoptics	All non-squint orthoptics
12	**Paediatric**	Non-orthoptic/squint pathology for under 17's
	Cataract	Be aware of CCG criteria for eligibility
	Laser YAG	YAG capsulotomy (not YAG PI)

All referrals should contain the following information as a minimum:

- Generic patient, GP and optometrist's details (name, address, DOB, GOC number etc.)
- Symptoms (onset, duration & frequency)
- Signs
- Refraction, VA (D&N) & previous VA (if known)
- Medical history & current medications
- Personal ocular history (including previous eye surgery)
- Family history
- Mobility
- Information given to the patient regarding the referral
- Proposed urgency: 'Emergency' (referred directly to HES)
  'Urgent' (2-4 weeks)
  'Routine' (up to 18 weeks)
  'Soon' referral is a flagged 'routine' referral and may take up to 18 weeks

Key

ROUTINE	SOON	URGENT	EMERGENCY

Additional recommended information/clinical investigations are listed for each sub-speciality.

Some patients might be suitable for an appointment with an experienced and well-equipped practitioner in the community (instead of the HES) which might be at a more convenient location; examples include community ophthalmology (C.Oph) and clinical optometry (Opt).

OCULOPLASTICS

Consider also: Present and historic photographs are useful in many cases. Taped and untapped field plots are useful in cases of ptosis/dermatochalasis.

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Blepharospasm		HES		
Dermatochalasis		HES		% of pupil covered, field plot, photo, duration
Ptosis - longstanding		HES		
Ptosis - acute onset		HES	'Emergency' in some neurological cases (e.g. neck pain in Horner's or headache in III nerve palsy)	% of pupil covered, field plot, photo, duration, motility, pupils
Ectropion		HES	'Soon' if marked corneal involvement (consider lid taping and lubrication)	Corneal involvement, severity of symptoms, duration of symptoms, presence of lagophthalmos, photos
Entropion		HES		
Trichiasis		OPT		
Trichiasis - recurrent		HES		
Epiphora (poor lacrimal patency)		C.OPH		Lid position, exposure, punctal stenosis/position, dry eye signs, MGD, duration of symptoms, tear strip height
Basal cell carcinoma (suspected)		HES		Enlarging, pain/itch/sore, superficial/deep, pigmented, bleeding, ulceration, duration, photos
Chalazion		HES		
Hordeolum		HES		
Squamous cell carcinoma		HES		
Pigmented lesion		HES	New/changing = '2 week wait'	
Exophthalmos/proptosis (new)		HES	'Urgent' if marked or painful 'Emergency' if severe pain	Thyroid function
Orbital blow-out fracture		HES		
Orbital/pre-septal cellulitis		HES		
Dacryoadenitis (acute)		HES		
Dacryocystitis (acute)		HES		

Key

ROUTINE	SOON	URGENT	EMERGENCY

EXTERNAL EYE DISEASE & CORNEA

Speciality-specific information to include: Lesion size, lesion depth, lesion location, pain (grade out of 10), photophobia, fluorescein stain, CL wear

	Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
	Unexplained painless red eye		OPT		
	Unexplained painful red eye		C.OPH		
LIDS	Blepharitis		OPT		
LIDS	Xanthelasma		C.OPH		
CONJUNCTIVA	Dry eye		OPT		
CONJUNCTIVA	Pinguecula		OPT		
CONJUNCTIVA	Sub-conjunctival haemorrhage		OPT		
CONJUNCTIVA	Allergic conjunctivitis		OPT		
CONJUNCTIVA	Bacterial conjunctivitis		OPT		
CONJUNCTIVA	Viral conjunctivitis		OPT		
CONJUNCTIVA	Giant papillary conjunctivitis		OPT		
CONJUNCTIVA	Conjunctival melanosis		C.OPH		
SCLERA	Episcleritis		OPT		
SCLERA	Scleritis		HES		
CORNEA	Unexplained corneal opacities		C.OPH		
CORNEA	Corneal dystrophy		C.OPH		
CORNEA	Keratoconus		HES		
CORNEA	Pterygium		C.OPH		
CORNEA	Pannus/micropannus		C.OPH		
CORNEA	Corneal neovascularisation (non-CL wear)		C.OPH		
CORNEA	Recurrent corneal erosion		C.OPH		
CORNEA	Corneal abrasion		OPT		
CORNEA	Marginal corneal ulcer		C.OPH	'Emergency' if diagnostic doubt/pain	
CORNEA	Bacterial corneal ulcer (microbial keratitis)		HES		
CORNEA	Herpes simplex keratitis		HES		
CORNEA	Herpes zoster ophthalmicus		HES		
CORNEA	Foreign body - superficial		OPT	'Soon' if asymptomatic	
CORNEA	Foreign body - deep		C.OPH		
CORNEA	Arc eye		HES		

Key

ROUTINE	SOON	URGENT	EMERGENCY

GLAUCOMA

Speciality-specific information to include: Disc size, cupping depth, rim:disc (Spaeth), +/- disc haemorrhage, +/- PDS, +/- PXF, enclose fields (even if normal), peripheral A/C depth (V/H), IOP machine used, F/H (OHT/glaucoma)

Do not refer into the glaucoma clinic: Non-glaucomatous field defects, retinal haemorrhages, tilted discs, neuro-ophthalmology conditions (e.g. swollen discs), myopic atrophy

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Intermittent angle closure symptoms		HES	Even if V/H 2	
Asymptomatic V/H1		C.OPH		
Single disc haemorrhage		C.OPH		
Two disc haemorrhages		C.OPH		
Bilateral disc haemorrhages		HES		
IOP 24-29 (by NCT)		OPT		
IOP 24-29 (by GAT) *nice.org.uk/guidance/ng81*		C.OPH		
IOP 30-34		C.OPH		
IOP 35-39		C.OPH	Some providers take IOP>44 to be 'emergency' - check local protocols	
IOP 44+		HES		
NTG suspect (discs and/or fields)		C.OPH		
PXF		C.OPH		
PDS		C.OPH		
Advanced POAG		HES		

Key

ROUTINE	SOON	URGENT	EMERGENCY

OTHER MEDICAL RETINA (OMR)

Speciality-specific information to include: Symptoms, previous VA (if known), description of macula/lesion (e.g. hypo/hyper pigmentation, flat/elevated, haemorrhage etc.), retinal images

Do not refer into the OMR clinic: Glaucomatous disc haemorrhages, vitreoretinal conditions

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Possible wet AMD (recent drop in VA, Amsler distortion) but no haemorrhages/oedema		C.OPH		Symptoms, previous VA (if known), description of macula (e.g. hypo/hyper pigmentation, flat/elevated, haemorrhage)
Likely wet AMD		HES	Fast-track	
Wet AMD with VA 6/120 or worse		HES		
Central serous retinopathy		HES		
Cystoid macular oedema		HES		
Bulls eye maculopathy		C.OPH		
Central / Branch retinal vein occlusion		HES		
Central / Branch retinal artery occlusion		HES		
Retinal embolus		HES		
Amaurosis fugax		HES		
Exudate(s) within arcades		HES		
Haemorrhage within arcades		C.OPH	'Urgent' if multiple haemorrhages or within 500um of foveola	
Toxoplasmosis		HES	'Emergency' if acute	
Retinitis Pigmentosa		HES		
Tamoxifen retinopathy		HES		
Choroidal naevus		C.OPH	'Urgent' if suspicious/high risk features	History (previous lesion discussion/imaging) and lesion description - Colour, Size, Shape, Position, Surface features (drusen, lipofuscin), Elevation
CHRPE - multiple		C.OPH		

Key

ROUTINE	SOON	URGENT	EMERGENCY

VITREORETINAL

Speciality-specific information to include: Symptomatology (timing, severity, type of symptoms) & signs (description and position)

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Asteroid hyalosis		C.OPH		
Synchysis scintillans		C.OPH		
Vitritis		HES		
Vitreous haemorrhage		HES		
Retinal hole		HES	'Urgent' if not flat or fluid present	
Lattice degeneration		C.OPH		
Retinoschisis		C.OPH		
PVD complicated		HES		
PVD uncomplicated		OPT	Anyone with photopsia/floaters should be seen either urgently or soon depending on onset and signs	Onset, frequency, duration, VA, any photopsiae (Point/arc/jagged plus onset/frequency/ duration)
Retinal detachment		HES		
Symptomatic retinal breaks and tears		HES		
Epiretinal membrane		C.OPH	Even if symptomatic with reduced VA/Amsler distortion	Spontaneously reported distortion, diplopia, spontaneously closing 1 eye to read/sharpen image
Macular hole		C.OPH	Even if reduced VA / Amsler distortion	

SYMPTOM-BASED REFERRALS

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Floaters - longstanding but worsening		OPT	Anyone with photopsia/floaters should be seen either urgently or soon depending on onset and signs. Flashes and floaters with an onset within 2 weeks and a history of trauma, myopia over -6, family history of RD, previous RD/vitreoretinal investigations, lattice, operculum and/or retinal/vitreous haemorrhage should be referred urgently to HES	Onset, frequency, duration, VA, any photopsiae (Point/arc/jagged plus onset/frequency/ duration). For community investigation, a second dilated fundus examination is recommended after approximately 2 weeks, preferably by a different practitioner
Floaters – small number, recent onset, no photopsiae		OPT		
Floaters - recent onset with photopsiae +/- reduced VA		HES		
Recent onset photopsiae		OPT		
Longstanding photopsiae		OPT		
Vitreous detachment symptoms with pigment in the vitreous		HES		

Key

ROUTINE	SOON	URGENT	EMERGENCY

NOT OTHERWISE SPECIFIED (NOS)

	Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
A/C	Asymptomatic A/C cells/flare		C.OPH		
	Asymptomatic KP		C.OPH		
	Hyphaema		HES		
	Hypopyon		HES		
IRIS	Abnormal iris pigmentation		C.OPH		
	Iris melanoma		HES	'Soon' for iris pigment / lump / cyst	
	Iritis / anterior uveitis		HES		
	Rubeosis		HES		
Giant Cell (Temporal) Arteritis			HES		

LOW VISION

Speciality-specific information to include: Near W.D., current and previous LVAs with approximate dates, Registration status (SI/SSI)

Consider also: Urgency is also influenced by risks in the home, history of depression, falls (previous/at risk) etc.

Clinics may not be ophthalmologist-led therefore a referral to the appropriate speciality may be required to request Registration (SI/SSI), e.g. OMR for macular disease, glaucoma for glaucomatous loss etc.

Key

ROUTINE	SOON	URGENT	EMERGENCY

NEURO-OPHTHALMOLOGY

Speciality-specific information to include: Good history and examination, especially of optic nerve function: VA, colour vision, pupils and fields.

Consider also: Disc margins, motility, headaches, monocular colour vision/red desat.

Do not refer into the neuro-oph. clinic: Non-neuro conditions, e.g. non-specific field defects, glaucomatous discs, squint/orthoptics, neurology cases

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Afferent pupil defect (new)		HES	Varies from 'soon' to 'emergency' depending on history and other signs	Check ocular motility in pupil cases to exclude other cranial nerve involvement
Anisocoria		HES	Asymptomatic/incidental observation may be suitable for 'routine' C.OPH review	
Horner's syndrome		HES	'Emergency' if acquired	Neck pain
Visual agnosia		HES		
Hemianopia/Quadrantanopia		HES	If asymptomatic/incidental finding then could be less urgent (e.g previous history of TIA or stroke)	
Anterior ischaemic optic neuropathy (AION)		HES		
Retrobulbar/optic neuritis		HES		
Papilloedema		HES		
Optic disc oedema		HES		
Minimally swollen disc without haemorrhage, normal VA and colour		C.OPH		
Optic disc haemorrhage (multiple/bilateral)		HES		
Optic disc haemorrhage (single)		C.OPH	Sooner if additional pathology/symptoms	
Optic disc pallor/optic atrophy		HES		
Toxic optic neuropathy		HES		
Nutritional optic neuropathy		HES		
Optic disc pit		C.OPH	'Urgent' if macular fluid	
Optic disc coloboma		C.OPH		
Optic disc drusen		C.OPH		
Myelinated nerve fibres		OPT		
Tilted disc/unusual cupping		OPT		

For Amaurosis fugax see page 7. For GCA see page 9.

Key

ROUTINE	SOON	URGENT	EMERGENCY

SQUINT / OCULAR MOTILITY (ADULT)

Speciality-specific information to include: C.T distance & near (constant vs intermittent, R/L/alt. and eso/exo/hyper/hypo), motility, diplopia and pupils. Comment on ocular health (especially posterior eye)

Do not refer into the adult squint clinic: Monocular diplopia, asthenopia/eye strain and refractive error

Condition	Urgency	Provider	Notes on Urgency	Additional Clinical Information to Include
Sudden onset squint		HES	'Urgent' if neurological	
Longstanding but worsening squint		HES		
Pain/discomfort on motility		HES		
Mild underaction with diplopia on peripheral gaze		HES		
Sudden onset diplopia		HES	'Emergency' if motility/pupil involvement etc.	Differentiate diplopia caused by reduction in motility from decompensating phorias, which can also cause double vision. Differentiate monocular from binocular diplopia
Longstanding but worsening diplopia		HES		
Sudden onset nystagmus		HES	'Emergency' if symptomatic/ other comorbidities	

Key

ROUTINE	SOON	URGENT	EMERGENCY

PAEDIATRICS AND ORTHOPTICS

Speciality-specific information to include: Type of squint (constant vs intermittent, R/L/alt. & eso/exo/hyper/hypo), motility and diplopia. Cycloplegic refraction is good to do for all children. Pupils and colour vision are particularly useful in neuro–paediatrics. Comment on ocular health (especially posterior eye)

Consider also: Refer to orthoptics in the first instance if querying amblyopia/squint and fundus normal. If unsure, refer sooner rather than later – especially with children.

	Condition	Urgency	HES Only	Notes on Urgency	Additional Clinical Information to Include
	Reduced accommodation		OPT		
	Reduced NPC		OPT		
	Recurrent bacterial conjunctivitis		HES	Irrespective of age	
	Blocked NLD		HES	Don't send under age 1 unless recurrent problems and eye itself red	
	Chalazion/hordeolum		HES	Irrespective of age	
	Ptosis		HES	'Urgent' if blocking visual axis in a baby. 'Soon' if age under 7. 'Emergency' if pain/other pathology e.g. reduced motility	
	Ophthalmia neonatorum		HES		
	No definitive red reflex (GP/photo)		HES		
VA	Unexplained bilateral reduced VA		HES	'Soon' if 6/18 or worse	
VA	Amblyopia (age under 8)		HES	'Soon' if 6/24 or worse	
SQUINT	New intermittent squint		HES	'Urgent' if VI nerve – (motility, change in VA or diplopia) Intermittent squint at age under 6 months is normal and doesn't necessarily need referral	
SQUINT	New constant squint		HES	'Urgent' if VI nerve – (motility, change in VA or diplopia)	Appearance of sudden onset might be an intermittent which has become constant – so take a careful history
SQUINT	Longstanding but worsening squint		HES		
MOTILITY / DIPLOPIA	Sudden onset diplopia		HES	'Emergency' with motility/pupil involvement etc.	
MOTILITY / DIPLOPIA	Longstanding but worsening diplopia		HES		
MOTILITY / DIPLOPIA	Pain/discomfort on motility		HES		
NYSTAGMUS	Sudden onset nystagmus		HES	'Emergency' if symptomatic/other comorbidities	
NYSTAGMUS	Longstanding nystagmus not previously investigated		HES		
NYSTAGMUS	End point nystagmus		HES		

Key:

ROUTINE	SOON	URGENT	EMERGENCY