Primary Care Referral Guidelines – Ophthalmology

IMMEDIATE REFERRAL TO THE EMERGENCY DEPARTMENT

Please discuss all urgent referrals with our Eye Admitting Officer - call switchboard 9929 8666

- Sudden onset of new distortion of central vision
- Sudden loss of *central* vision
- For other indications for referral, please see below

Urgent referrals to specialist eye clinics

Please **fax** all urgent (specialist eye clinic) referrals to the Eye and Ear Hospital Patient Services and Access team on 9929 8408, to ensure these are processed without delay.

About

These guidelines have been developed in line with the Victorian Statewide Referral Criteria, to ensure there is timely access for patients to specialist clinics in public hospitals, by improving the quality and appropriateness of referrals. For more information regarding the Statewide referral criteria, please visit src.health.vic.gov.au/about.

These guidelines are also not designed to assist with a definitive diagnosis, but rather to identify key clinical thresholds requiring referral to the Eye and Ear Hospital for specialist diagnosis.

Table of Contents

1. Ophthalmology conditions not accepted

The following conditions are not routinely seen at the Royal Victorian Eye and Ear Hospital and may be appropriately managed by a local ophthalmologist or optometrist until they reach the clinical thresholds identified in these Referral Guidelines.

Condition	Description
Age-related Macular Degeneration (AMD)	◆ AMD for review ◆ Family history but asymptomatic ◆ Retinal Pigment Epithelial changes (previously called 'dry AMD') in a patient >55 yrs old ◆ Stable Drusen ◆ Early Intermediate, or stable Geographic Atrophy (GA) ◆ Patients already treated with anti-VEGF in the community, including interstate or overseas
Blepharitis	◆ Chronic (not severe) with itchy eyes ◆ No lid or corneal changes ◆ Without an Optometric/Ophthalmic report
Blocked Nasolacrimal Duct	◆ Child less than 2 years old
Cataract	◆ Without an Optometric/Ophthalmic report ◆ BCVA in affected eye ≤6/9 (some exceptions) ◆ Congenital Cataract in a child <18yrs old ◆ Patient does not want surgery ◆ Lens opacities that do not have an impact on the patient's activities of daily living
Chalazion	◆ Present for less than 8 weeks and no other contraindications ◆ Where conservative treatment not attempted
Conjunctivitis	• With no other signs or symptoms • With mild symptoms (unless child on ocular steroids) • Without an Optometric/Ophthalmic Report
Cosmetic Contact Lens	• New or replacement (functional or cosmetic)
Defence Vision Exam	• All vision assessments for Defence Services are to be completed by a community ophthalmologist
Diabetes	◆ Newly diagnosed or established for fundus exam (screening), including during pregnancy ◆ Non-proliferative (background) diabetic retinopathy (minimal to moderate NPDR) ◆ Non-centre involving macular oedema ◆ Previously treated with anti-VEGF in the community, including interstate or overseas

Condition	Description
Driving Assessment	• All vision assessments for the suitability of driving are to be completed by a community optometrist or ophthalmologist
Dry eyes	◆ Longstanding (even if no relief of symptoms with regular use of lubricants) ◆ Without corneal changes • Without an Optometric/Ophthalmic report
Entropion/ Ectropion	• No corneal involvement or lid irritation
Epiphora (watery eye)	◆ Child less than 2 years old ◆ Intermittent watery • Without Optometric/Ophthalmic report
Epiretinal membrane	• Asymptomatic, VA 6/9 or better and no significant distortion
Excess Eyelid Skin (Dermatochalasis)	• Not obscuring line of sight (excess skin of upper eyelids with skin NOT resting on the lashes in straight ahead gaze and therefore NOT obscuring line of sight)
Flashes	• With associated history of migraine
Floaters	• Longstanding (>6/52) with no other symptoms • Posterior Vitreous Detachment (PVD) for review and no new symptoms
Genetic Eye Conditions	• Without an Optometric/Ophthalmic report (unless for family planning)
Glaucoma	• Requests for the diagnosis or ongoing management of: ○ Glaucoma suspect ○ Ocular hypertension ○ Stable early and moderate glaucoma
Headaches	• When reading • Migraine with no ophthalmic symptoms • Tension headaches with no ophthalmic symptoms
Itchy eyes	• Longstanding • Children or adults with no other symptoms • Without an Optometric/Ophthalmic Report
Narrow Angles	• Without an Optometric/Ophthalmic Report
NDIS assessment	• Needs to be completed by community optometrist

Condition	Description
Neuro-Ophthalmology	◆ Children under 16yrs of age with BIH or Children with Optic Nerve Coloboma; needs to be referred to Royal Children's Hospital (RCH) ◆ Children under 16yrs with suspected papilloedema; **should be advised to attend RCH ED** ◆ Unless under 18yrs of age, non-existing RVEEH patients may be forwarded to the Alfred Hospital Neuro-Ophthalmology Unit ○ Including: Optic Neuritis, sudden onset diplopia (adults), sudden ptosis, suspected optic disc drusen, BIH, possible pupil defects, adult with Ethambutol toxicity, acquired nystagmus, neurofibromatosis review, suspected myasthenia gravis, intracranial tumours, recent CVA for assessment, and second opinion for any neuro-ophthalmological condition
Oculoplastics	• Dermatochalasis NOT affecting vision • Children under 2yrs with suspected or known blocked nasolacrimal duct; needs to be referred to RCH
Pharmaceutical toxicity	• Baseline screening or check prior to commencement of Ethambutol or Plaquenil (refer to the Australian College of Optometry) • Review of adult with known, high risk, or suspected Ethambutol toxicity (unless existing RVEEH patient)
Prosthesis / Artificial Eye	• Scleral shell contact lens • Review of existing Prosthesis • Replacement of lost or damaged prosthesis *Refer directly to Ocularist
Pterygium / Pingueculum	• Asymptomatic pterygium and does not require surgery • Pinguecula with symptoms of dry eyes and irritation
Ptosis	• Child under 2 years old (needs to be referred to Children's Hospital)
Recurrent Corneal Erosion (RCES)	• History of RCES or currently not 'active' • Monitoring of previously discharged Corneal Clinic patient with no indication of progression
Red eye	• Chronic and mild • No associated l vision loss or pain
Refraction	• For glasses check or any refractive investigation • Refractive laser surgery • Blurred vision check (adult or child)

Condition	Description
Retinal	• Asymptomatic Epiretinal Membrane (ERM), with VA 6/9 or better, and no impending macular hole or schisis • Chronic or old artery occlusion (BRAO/CRAO) with no new symptoms
Toxoplasmosis	• Inactive (even if on prophylactic treatment); For optometry review
Trichiasis	• With no corneal involvement • Removal of eyelash in primary health care sector
Visual Field Assessment	• Post stroke or other known neurological/neurosurgical condition • Estermann visual field test (for driving assessment)

2. Clinic Timeframe Categories

The following table gives an indication of the timeframe within which patients of different acuity are expected to be seen.

Category	Definition
Emergency	A patient whose condition is identified from referral details as having an acute sight or life-threatening condition where immediate medical or surgical intervention is required ***Discuss with the Admitting Officer in the Emergency Department – call switch on 9929 8666 – to confirm immediate referral to the Emergency Department***
Urgent: (within 1 week) Waiting list: Category **1A**	A patient whose condition is identified from referral details as having the potential to deteriorate quickly to the point that it may become an emergency.
Urgent: (1 week to 30 days) Waiting list: Category **1B**	A patient whose condition is identified from referral details as having the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly.
Routine (30-90 days) Waiting list: Category **2**	A patient whose condition is identified from referral details as causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.
Routine: (90-365 days) Waiting list: Category **3**	Patients whose condition is identified from referral details as being unlikely to deteriorate quickly and does not have the potential to become an emergency.
Primary Care - not accepted	Patients whose condition is identified from referral details as requiring primary care, and not reaching the threshold criteria for the hospital's specialist services. Refer to the Primary Care Management Guidelines – The Royal Victorian Eye and Ear Hospital Patients over 45 years of age should have regular eye examinations with an ophthalmologist/optometrist every three years.

3. Referral Resources

In order to triage accurately to the most appropriate specialist clinic, within a clinically suitable timeframe, it is critical that we receive accurate and detailed referral information. In most cases, this **will require a report from local ophthalmologist or optometrist within the last 3 months**.

If available, email an OCT with the patient's name and date of birth on the image for all referrals for macular conditions to vruelectronicimages@eyeandear.org.au. Please ensure you have the patient's consent to email the image.

Referral information

All referrals must include:

- Clear statement of symptoms
- Duration of problem
- Functional impact
- Risk factors
- Date of last eye examination (within last 3 months) – include report
- Current diagnostic report from Optometrist or private Ophthalmologist if indicated in the referral guidelines
- If the person identifies as Aboriginal or Torres Strait Islander

**Additional information may be required for specific ocular conditions - please refer to the referral guidelines below for further details.*

If the GP is unable to ascertain the clinical information required to identify the thresholds, this can be obtained from an ophthalmologist or optometrist.

Ophthalmologist and Optometrist directory

If the referring GP is unable to ascertain the clinical information required to identify the thresholds, this can be obtained from an Ophthalmologist or Optometrist.

- Local ophthalmologists and optometrists can be located at https://about.healthdirect.gov.au/

  (Type in 'Suburb/Town or Postcode' > Select the 'Practitioner' tab > Select Ophthalmologist or Optometrist in 'Specialty' > Select 'Site search' for clinics or 'Practitioner Search' for specific people).

- Optometrists can also be located through https://www.optometry.org.au/gps-health-care-professional/gps
- Ophthalmologists can also be located through https://ranzco.edu/

4. Referral Guidelines

DIAGNOSIS		
AMD		
Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Choroidal Neovascularization (CNV), also known as Wet AMD • Blurred or distorted central vision • Amsler grid showing central vision changes	• Optometrist/Ophthalmologist report including BCVA, refraction & retinal examination performed in the last 3 months • RVEEH will accept newly diagnosed untreated patients, and where possible will facilitate their discharge for ongoing management in the community once stable (in line with SRC) • New patients will only receive 3 anti-VEGGF treatments at the Eye and Ear • **Patients that have received ANY anti-VEGF treatment in the community, including interstate or overseas, <u>will not be accepted</u> as a patient at RVEEH for continued management**	• Urgent treatment to preserve central vision
Cataract / Lens		
Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Cataract • Patient wants surgery • Best Corrected Visual Acuity (BCVA) • Cataract type • Symptomatic	• Optometrist/ophthalmologist report including BCVA, type of cataract, refraction details (each eye) and dilated retinal examination performed in the **last 3 months** **Refer** • BCVA of cataract affected eye is CF/HM/LP – refer urgently (to specialist eye clinics) • Worse than or equal to 6/12 BCVA in cataract affected eye • Symptomatic cortical or posterior-subcapsular cataract (regardless of vision) • Known history of angle closure or narrow AC's • Professional driver and BCVA 6/9 or worse • Only functional eye	Cataract Surgery: • Surgical removal of the natural lens and implantation of an Intra-ocular Lens

Cataract cont'd…	**Also provide details where applicable:** ◆ If patient is diabetic and there is a poor/no view of the retina during the eye assessment ◆ Past history of vitrectomy in affected eye ◆ Symptomatic anisometropia ◆ If the person is a carer ◆ If the person is a falls risk	
Posterior Capsular Opacity (PCO) ◆ Symptomatic ◆ Reduced visual acuity as compared to 1/12 post-Cataract surgery	◆ Optometrist/Ophthalmologist report including BCVA, refraction & retinal examination performed in the last 3 months	◆ YAG Laser capsulotomy
Cornea/Conjunctiva Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Corneal Ulcers	◆ **Refer immediately to ED**	◆ Medical management ◆ Treatment of ulcer to manage pain and improve vision
Corneal foreign body ◆ If unable to remove FB ◆ With rust ring	◆ **Refer immediately to ED**	◆ Check for corneal damage with fluorescein ◆ Management of pain and corneal injury
Corneal decompensation ◆ Bullous keratopathy ◆ Endothelial keratopathy ◆ Band Keratopathy	◆ Optometrist/Ophthalmologist report performed in the last 3 months ◆ Refer urgently (to specialist eye clinics)	◆ Medical or surgical management of corneal disease
Corneal graft rejection	◆ Optometrist/Ophthalmologist report performed in the last 3 months ◆ Refer urgently (to specialist eye clinics)	◆ Medical management
Fuch's dystrophy	◆ Optometrist/Ophthalmologist report performed in the last 3 months ◆ With corneal decompensation and bullae - Refer urgently (to specialist eye clinics)	◆ Medical management

Keratoconus	• Optometrist/Ophthalmologist report performed in the last 3 months • With hydrops - Refer urgently (to specialist eye clinics) • With CCT <410 microns - Refer urgently (to specialist eye clinics) • With progression for treatmentmust include **evidence of progression** (with past refractions and/or corneal topography)	• Management with contact lenses • Corneal Cross Linking • Surgical treatment
Keratitis (Marginal, Microbial) • Red eye, Foreign body sensation, photophobia, epiphora, blurred vision	• Optometrist/Ophthalmologist report performed in the last 3 months • **Refer immediately to ED**	• Medical or surgical treatment of keratitis to reduce pain and improve vision
Corneal or Conjunctival lesion	• Optometrist/Ophthalmologist report performed in the last 3 months • Refer urgently (to specialist eye clinics)	• Medical or surgical treatment
Pterygium • Patient wants surgery • Red / irritated / distorting vision	• Optometrist/Ophthalmologist report performed in the last 3 months	• Surgical removal +/-conjunctival grafting

Diabetic Eye Disease		
Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Severe Non-Proliferative Diabetic Retinopathy Proliferative Diabetic Retinopathy Diabetic Macular Oedema (DMO) • Centre involving only Vitreous Haemorrhage	• Optometrist or Ophthalmologist report including best corrected visual acuity, refraction, and retinal assessment performed in the last 3 months. **Refer:** • Diabetes with sudden Loss of Vision; **Refer immediately to ED** • Vitreous Haemorrhage; Refer urgently (to specialist eye clinics) **Provide if available:** • Type of diabetes, duration of disease • Any previous eye treatments (e.g. intravitreal injections, retinal laser, surgery) • Optical coherence tomography (OCT) result to	• Medical, Laser and Surgical management of diabetic retinopathy for the preservation of vision

Diabetic Eye Disease cont'd…	vruelectronicimages@eyeandear.org.au • Recent HbA1c result & Fasting lipid results • Blood pressure readings **Patients that have received ANY anti-VEGF treatment in the community, including interstate or overseas, will not be accepted**	

Eye inflammation/ infection		
Evaluation	Threshold Criteria/ Referral Criteria	Tertiary Care Management
Viral / bacterial conjunctivitis with discharge • Red eye with reduced vision • Suspected iritisSuspected corneal ulcerSuspected herpes simplex infectionHerpes zoster ophthalmicus with eye involvement	• Failure to respond to topical treatment within 3 days **Refer immediately to ED**	• Medical management
Allergic eye disease (Vernal catarrh) • A form of conjunctivitis, often in younger age group • Severe itch • Stringy mucoid discharge • Typical thickened swollen "leathery" inferior fornix +/- cobblestone papillae, upper lid.	• Optometrist/Ophthalmologist report with detailed symptoms • Severe or with decreased vision – **Refer immediately to ED** • Child using ocular steroids – Refer urgently (to specialist eye clinics) • Adult or child with moderately severe symptoms – Refer urgently (to specialist eye clinics)	• Topical antihistamines
Nasolacrimal Duct Obstruction (NLDO) Punctal stenosis Watery eye	• Optometrist/Ophthalmologist report performed in the last 3 months • NLDO with dacryocystitis - Refer urgently (to specialist eye clinics) • Refer adults and children (>2 years of age)	• Surgery -DCR

Peri-orbital (Preseptal) + Orbital cellulitis • Big puffy eye • Swollen lid ++ • Unable to open eye • Diplopia • Loss of vision	• **Refer immediately to ED**	• Medical management
Eyelids/ Malposition Evaluation	Threshold Criteria/ Referral Criteria	Tertiary Care Management
Sub-Tarsal Foreign Body • If unable to remove FB • With rust ring	• **Refer immediately to ED**	• Management of pain and removal of FB
Blepharospasm	• Intermittent or constant	• Medical management
Blepharitis • Severe and persistent blepharitis with corneal or lid changes • Not responding to treatment with warm compressions and lid scrubs	• Optometrist/Ophthalmologist report performed within last 3 months detailing past treatment • With photophobia and/or blurred vision - Refer urgently (to specialist eye clinics)	• Medical management
Ectropion & Entropion • With corneal involvement • Lid irritation or watery eyes • Unmanageable pain	• Optometrist/Ophthalmologist report performed within last 3 months	• Prevention of corneal disease • Check for corneal damage with fluorescein • Surgical management
Excess eyelid skin (Dermatochalasis)	• Optometrist/Ophthalmologist report performed within last 3 months • Obscuring line of sight (Excess skin of upper eyelids with skin resting on the lashes in straight ahead gaze and obscuring line of sight, as per MBS definition 45617)	Surgical management

Ptosis • Drooping upper eyelid • Unilateral or Bilateral • With or without neurological signs • Obscuring line of sight	• Sudden onset (adult & children) – Refer urgently (to specialist eye clinics) • Over 2 years of age	• Diagnosis and management of underlying neurological cause

Chalazion / Stye
• Chronic (>8 weeks)
• Non-responsive to warm compresses
	• Optometrist/Ophthalmologist report performed within last 3 months
	• Infected and possible cellulitis- **Refer immediately to ED**
	• Children:
	  ○ >4-6/52 duration if under 7 years old (amblyogenic)
	  ○ Duration >8/52 if over 7 years old
	  ○ Child less than 16 years with large lesion causing vision problems or ptosis - Refer urgently (to specialist eye clinics)
		• Surgical removal of chalazion

Lid lesions • BCC & SCC • Non-specific lid lesion • Benign papilloma	• Presumed (or confirmed) BCC, SCC – Refer Urgently (to specialist eye clinics) • Non-specific lid lesion increasing in size, changing colour - Refer urgently (to specialist eye clinics) • **Provide pathology report if available** • Optometrist/Ophthalmologist report performed within last 3 months if benign papilloma or non-specific lid lesion	• Surgical removal of cancerous and non-cancerous lesions
Prosthesis • Poor fit • Infection • Exposure	• Refer if existing prosthesis not fitting well and may require further surgery • With discharge/infection or extrusion/exposure of prosthesis/implant – Refer urgently (to specialist eye clinics) • Publicly funded replacement of existing prosthesis will only be considered for patients who have had previous eye surgery at RVEEH (as patient of the Oculoplastic or Ocular Oncology clinic) • **General review of any existing prosthesis (including replacement of lost or damaged prosthesis) is to be managed in the community by an Ocularist**	• Management of prosthesis

Eye pain/ Discomfort Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Corneal Ulcer Corneal Foreign Body	• See "Corneal/Conjunctiva" section	
Contact Lens Wearer • Eye discomfort • Cease contact lens wear	• Pain and discomfort- **Refer immediately to ED** • Non-acute pain, mild irritation: optometrist/ophthalmologist report performed in the last 3 months	• Management of pain • Prevention of vision loss
Sub Tarsal Foreign Body	• See "Eyelids/Malposition" section	
Proptosis • Acute, chronic, endocrine associated	Refer urgently (to specialist eye clinics) if: • Sudden/recent onset • With vision loss (or threat to vision) • With redness and pain – including on eye movements • With diplopia or restricted eye movement • In presence of a space occupying lesion • Thyroid Eye Disease with inflammation Routine referral if: • Stable and longstanding • In presence of inactive Thyroid Eye Disease • Non-inflammatory • Idiopathic / no cause provided • No vision loss/threat to vision • **Include imaging report if available**	• Emergency treatment to prevent vision loss
Optic Neuritis • Suspected • New diagnosis (child)	• Suspected optic neuritis (adult or child) - **Refer immediately to ED** • Sudden loss of vision • Pain on eye movements • Child with <u>new</u> diagnosis of Optic Neuritis - Refer urgently (to specialist eye clinics)	• Emergency medical treatment to prevent vision loss

Genetic Eye Disease

Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Inherited Eye Diseases • For genetic counselling or electrophysiology testing	• Optometrist/ ophthalmologist report performed within the last 3 months (unless family planning) • Where genetic testing/genetic family planning is requested and patient or patient's partner is pregnant – Refer urgently (to specialist eye clinics) • For Lebers Hereditary Optic Neuropathy – Refer Urgently (to specialist eye clinics)	• Electrodiagnostic testing to confirm diagnosis • Genetic investigation to confirm diagnosis and heritability of disease • Genetic counselling
Genetic Disease with Ophthalmic Component • For genetic counselling or electrophysiology testing	• Optometrist/ophthalmologist report performed within the last 3 months • For Para-neoplastic syndromes requesting electrophysiology testing – Refer urgently (to specialist eye clinics)	• Electrodiagnostic testing to confirm diagnosis • Genetic investigation to confirm diagnosis and heritability of disease • Genetic counselling

Glaucoma

Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
The following will be identified by a glaucoma assessment by local ophthalmologist or optometrist: Glaucoma with evidence of progression Significant increased Intraocular Pressure (IOP) ≥26 mmHg Narrow Angles Advanced Glaucoma/ Uncontrolled Glaucoma End stage glaucoma	• Optometrist/ophthalmologist report including VA, refraction, IOP, pachymetry, visual fields & disc assessment performed in the last 3 months • Uncontrolled IOP/> 26 mmHg – Refer urgently (to specialist eye clinics) Document presence of any of the following: • Secondary glaucoma • If the patient has only one seeing eye • Multiple ocular surgeries • Ocular trauma Provide if available: • Optical coherence tomography (OCT) including retinal never fiber layer results • Optic disc photos • Gonioscopy	• Control of the IOP with: ○ Eye drops ○ Laser treatment ○ Surgical treatment Prophylactic Iridotomy ○ To prevent acute angle closure glaucoma ○ Co-management with community providers where possible/clinically appropriate

Acute Angle Closure Glaucoma ◆ History of glaucoma ◆ Red painful eye ◆ Significant reduction or loss of vision ◆ Photophobia ◆ Partly opaque cornea ◆ Hard, painful eye	◆ **Refer immediately to ED**	◆ Emergency medical management
Neuro-Ophthalmological Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Raised intracranial pressure (ICP) ◆ +/- Neurological signs/symptoms	◆ Suspected intracranial hypertension - **Refer immediately to ED** ◆ Benign intracranial hypertension for review or second opinion (routine referral)	◆ Emergency medical management
Giant cell arteritis (GCA) and other vascular disease ◆ Immediate discussion with ophthalmologist for acute sight threatening giant cell arteritis is mandatory ◆ Immediate ESR/CRP/FBE **(no need to wait for results)**	◆ Headache with throbbing sensation on side of back of head, jaw pain, blurred vison/vision loss - **Refer immediately to ED** ◆ If pathology is suspected with confirmatory signs/symptoms and raised ESR/CRP- Refer urgently (to specialist eye clinics)	◆ Emergency medical management
Headache with ocular pathology/symptoms Associated with: ◆ Diplopia or blurred vision ◆ Visual disturbance or reduced vison ◆ Symptoms of Amaurosis Fugax	◆ **Refer immediately to ED**	
Papilloedema (swollen optic nerve) ◆ Detected on routine eye exam ◆ Suspected with headache or intracranial hypertension	◆ With headache or raised ICP – **Refer immediately to ED*** * Under 16 years of age (with or without headache) – **Refer to Royal Children's Hospital ED** ◆ Detected on routine eye exam with no headache, normal visual field – Refer urgently (to specialist eye clinics)	

Pupil Defects • Newly detected +/- visual symptoms or ptosis • Possible defects including anisocoria, Horner's, Aide's	• Newly detected with visual symptoms and/or ptosis – **Refer immediately to ED** • Newly detected (no visual symptoms or ptosis) – Refer urgently (to specialist eye clinics)	

Ocular Oncology

Any referral to the Oncology Unit must contain the following details/information:

- Name, date of birth

- Address, telephone number (incl mobile number if available)

- GP name, address and fax number

- Relevant ocular and systemic details

- Results of any recent blood tests or scans (Conjunctival biopsies should not be done and referral should not be delayed because of any pending investigations)

- Any old photographs of tumour (including the patient's name and D.O.B on each image) email to vruelectronicimages@eyeandear.org.au* Please ensure you have the patient's consent to email the images.

- Patient's special needs and preferences

Referrals for possible cancer should reach the hospital within 48 hours of presentation. Patients should be given the hospital contact centre phone number (9929 8500) if hospital has not been in contact with an appointment offer within two weeks.

Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Iris Lesion/Iris Cyst	• Optometrist/ophthalmologist report performed within the last 3 months • Refer urgently (to specialist eye clinics)	• Oncological management
Ectropion Uveae	• Optometrist/ophthalmologist report performed within the last 3 months • Refer urgently (to specialist eye clinics)	• Oncological management
Conjunctival Melanoma	• Optometrist/ophthalmologist report performed within the last 3 months • Refer urgently (to specialist eye clinics)	• Oncological management
Choroidal Naevus • Raised with pigment • Flat for opinion	• Optometrist/ ophthalmologist report performed within last 3 months • Raised with pigment- Refer urgently (to	• Monitoring of lesion

	specialist eye clinics)	
Intraocular Melanoma (presumed)	• Optometrist/ ophthalmologist report performed within last 3 months • Raised with pigment- Refer urgently (to specialist eye clinics)	• Oncological management
	•	•

Retinal Disorders

If available, email all electronic OCT results (including the patient's name and D.O.B on each image) to vruelectronicimages@eyeandear.org.au

* Please ensure you have the patient's consent to email the images.

Evaluation	Threshold Criteria/Referral Guidelines	Tertiary Care Management
Epiretinal membrane (ERM) • Distorted vision	• Optometrist/ophthalmologist report performed within the last 3 months • Symptomatic and VA ≤ 6/12 • With traction, for possible surgery • Include OCT (colour) report if available via email to vruelectronicimages@eyeandear.org.au	• Surgical management
Macular hole • Partial thickness • Full thickness	• Optometrist/ophthalmologist report performed within last 3 months • Include OCT (colour) report if available via email to vruelectronicimages@eyeandear.org.au	• Surgical management
Retinal Vein occlusion • Central (CRVO) • Branch (BRVO	• Optometrist/ophthalmologist report performed within last 3 months - Refer urgently (to specialist eye clinics)	• Medical management
Retinal Artery Occlusion • Central (CRAO) • Branch (BRAO)	• **Refer immediately to ED**	• Medical management
Retinitis Pigmentosa • Suspected	• Optometrist/ophthalmologist report performed within last 3 months	• Electrodiagnostic testing to confirm diagnosis
Vitreous Haemorrhage	• Optometrist/ophthalmologist report performed within last 3 months • Known diabetic retinopathy post PRP laser – Refer urgently • New vitreous haemorrhage - no previous history - **Refer immediately to ED** • Include OCT (colour) report if available via email to	• Surgical management

	vruelectronicimages@eyeandear.org.au	
Retinal Detachments/Tears/Holes • Sudden unilateral loss of vision • History of trauma Retinal detachments/ Tears/Holes cont'd… • With or without preceding floaters, flashes, or a "veil" over the vision • History of severe short-sightedness	• **Refer immediately to ED**	• Surgical or laser management of the detachment/tear/hole
Central Serous Retinopathy • Distorted central vision • Amsler grid changes	• Optometrist/Ophthalmologist report performed within last 3 months • New onset- Refer urgently (to specialist eye clinics)	• Medical management
Choroidal Naevus • Raised with pigment • Flat for opinion	• Optometrist/ ophthalmologist report performed within last 3 months • Raised with pigment- Refer urgently (to specialist eye clinics) • Include OCT (colour) report if available via email to vruelectronicimages@eyeandear.org.au	• Monitoring of lesion
Intraocular melanoma/ intraocular mass • Presumed/confirmed	• Optometrist/ophthalmologist report performed within last 3 months • Refer urgently (to specialist eye clinics)	• Surgical and medical treatment for the preservation of vision and the prevention of metastatic disease

Strabismus (Squint)

Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Strabismus (Squint)/ Ocular Misalignment • Amblyopia (lazy eye) • Adults and children with developmental, neurological and	• Optometrist/Ophthalmologist report performed within last 3 months • Adults/Children sudden onset – Refer urgently (to specialist eye clinics) • Children with new or longstanding strabismus or amblyogenic conditions (eg: anisometropia) – Refer urgently (to specialist eye clinics)	• Surgical management of ocular misalignments • Monitored occlusion therapy to treat amblyopia in children • Prescription of prism aids to reduce or eliminate double vision.

other problems • With intermittent diplopia • Thyroid Eye Disease (TED) / Thyroid Associated Ophthalmopathy • Cranial Nerve Palsies	• TED with acute/recent onset diplopia – Refer urgently (to specialist eye clinics) • Adults longstanding squint for consideration of surgery (routine referral)	
Trauma Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Adnexal (lid) trauma • Full thickness lacerations of the upper lid • Suspected canalicular or levator disruption	• **Refer immediately to ED**	• Surgical repair of damage caused by trauma to maintain functional anatomical integrity
Blunt trauma • Hyphema • Traumatic mydriasis • Loss of vision • Vitreous Haemorrhage	• **Refer immediately to ED**	• Medical management
Chemical burns • Irrigate all chemical injuries immediately for at least 10 mins with Saline, Hartmann's solution or Water	• Provide History (acid, alkali, other) • Phototoxic burns/UV burns - **Refer immediately to ED**	• pH neutralisation of ocular surfaces • Management of resulting injury
Contact lens wearer	• If acute, or associated ulcer – **Refer immediately to ED**	• Medical management
Foreign bodies • Corneal within pupil zone • Under upper eyelid • If difficult, incomplete, or unable to remove • If pain persists or increases • Intra-ocular	• **Refer immediately to ED**	• Removal of foreign body • Management of wound/injury
Globe Rupture, Penetrating Injury,	• **Refer immediately to ED**	• Surgical repair

suspected Intra-Ocular Foreign Body		
Orbital fracture • Recent trauma • Known fracture untreated • Treated for diplopia assessment	• Recent trauma - **Refer immediately to ED** • With known orbital wall fracture not yet treated - Refer urgently (to specialist eye clinics) • For diplopia assessment (orbital wall fracture already treated) • **Provide imaging report (CT scan) if available**	• Surgical repair of fractures and removal of entrapped orbital contents
Retinal detachments/ Tears/Holes	• See "Retinal Disorders" section	

SYMPTOMS

Diplopia

Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Diplopia • Strabismus, • Adults and children with developmental, neurological, and other problems. • Thyroid Eye Disease (TED) • Nerve Palsies • Mysathenia Gravis	• Optometrist/Ophthalmologist report performed within last 3 months • If any of the following - Refer urgently (to specialist eye clinics) ○ Sudden onset ○ Children under 18yrs of age ○ With known orbital fracture not treated yet ○ With proptosis or known orbital mass ○ With diabetes ○ With TED and recent/acute onset diplopia ○ Post ocular surgery	• Surgical management of ocular misalignments • Monitored occlusion therapy to treat amblyopia in children • Prescription of prism aids to reduce or eliminate double vision.

Eye infections / Inflammation

Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Red Painful +/- Watery Eye If any of the following occur: • Fluorescein dye inserted in the eye cannot be blown from the nose after five minutes • Photophobia/redness	• Sudden onset with red eye, with pain, blurred vision, or acute discharge - **Refer immediately to ED** Optometrist/Ophthalmologist report performed within the last 3 months needed for: • Long standing watery eye not responsive to treatment • Intermittent, or chronic (moderate or	• Medical management

• Hazy and enlarged cornea • Frank suppuration • Excessive lacrimation	severe) red eye	

Eye pain/ Discomfort		
Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Dry eye • With corneal changes • Associated with known Sjogren's syndrome • Conjunctival inflammatory condition • With ocular pemphigoid	• Optometrist/ophthalmologist report performed within last 3 months • Painful and unresponsive to sustained lubrication over 2/52	• Management of ocular discomfort • Prevention of secondary corneal disease
Red eye with pain	• **Refer immediately to ED**	• Emergency management

Visual Disturbance / Vision Loss (non-cataract)		
Evaluation	Threshold Criteria/ Referral Guidelines	Tertiary Care Management
Sudden loss of vision • With/without pain on eye movements	• **Refer immediately to ED**	
Blurred vision	• With red eye or headache - **Refer immediately to ED** • Idiopathic - optometrist/ophthalmologist report performed within last 3 months	• Medical management
Visual Field Defect	• Optometrist/ophthalmologist report performed within last 3 months – must include VF test results • If binocular visual field loss (non glaucomatous) or acute VF defects with systemic symptoms – **Refer immediately to ED** • If not acute, not binocular and no loss of vision – Refer urgently (to specialist eye clinics) • In presence of intracranial tumour, space occupying lesion, CVA or Optoc Neuritis – Refer urgently (to specialist eye clinics)	• Medical management
Children's vision • with difficulty	• Optometrist/Ophthalmologist report	• Management of visual problems and prevention of future vision loss

with long distance vision • with longstanding reduced vision	performed within last 3 months • If under 8yrs of age and unequal vision – Refer urgently (to specialist eye clinics)	
Neuro-Ophthalmic Disorders • Sudden unilateral or bilateral loss of vision • Sudden Lid Ptosis • Sudden Double Vision • Pain on eye movements • Sudden visual field loss - confrontation field or formal field test results	• **Refer immediately to ED**	• Medical management
White pupil reflex in children	• Refer urgently (to specialist eye clinics)	• Management of sight threatening and potentially life-threatening condition
Floaters/ flashes • With reduced vision OR cobwebs/curtain over vision	• **Refer immediately to ED**	• Medical and/or surgical management