# CENTRAL MERSEY LOCAL OPTICAL COMMITTEE

## OPTOMETRIC REFERRAL GUIDELINES

The ocular conditions listed in this document are intended to reflect those that might be encountered in optometric practice and this list is not intended to be exhaustive. This guidance is to assist the referral process and offer advice. It does not remove the practitioner's professional responsibility to each patient.

Where the patient requires a routine referral to the Hospital Eye Service, the completed referral pro-forma should be faxed to the appropriate eye department, depending on the choice of the patient. All referrals will be prioritised by the ophthalmic department and the patient will be sent an appointment.

Occasionally it may be better to refer urgently. This guidance indicates typical examples and differences in procedure.

If your practice charges for further tests for referral refinement, e.g. Threshold visual fields, dilated fundoscopy, you should make the patient fully aware of all appropriate fees. If the patient declines follow up tests, you must refer to the HES if there is a reasonable suspicion of ocular disease or injury.

If the patient is being monitored in optometric practice, there is no need to inform the GP or the HES, unless the patient has diabetes or glaucoma. Patients requiring medical attention only and not requiring referral to the HES should be reported to a GP on the GOS18 form or headed notepaper.

**You should send a copy of each referral pro-forma to the patients GP.**

## Direct Referral Electronic Form

There is an electronic direct referral form available for direct optometric referrals. This allows each referral to be typed, printed and saved as a unique patient file on your practice PC. The form has highlighted sections for typing, drop-down menus and tick boxes. The benefits include better clarity and organisation of information along with reproducibility.

The form uses software, called Ominform Filler and is fairly simple to use. However, as it is an exe. File and includes sensitive patient information, it is not advisable to send this form via email.

## Referrals for AMD

The Royal College of Ophthalmologists has produced an atlas for AMD referrals. The atlas offers guidance on what requires referral and the most appropriate path for referral and also what doesn't require referral. As per the other advice in this document, the optometrist should still use their personal judgement in deciding to refer. It does not remove the practitioner's professional responsibility to each patient.

Cheshire and Merseyside Specialist Commissioning has a task force developing a strategy for AMD, which will include a local care pathway and framework for AMD referrals. However, this task force isn't expected to report until October 2007.

In the meantime, Aintree Hospitals NHS trust and St Pauls Eye Unit have indicated that they will accept direct referrals from optometrists using the RCO referral form. You could also use the general optometric referral form, particularly for less urgent AMD referrals.

The atlas and form are available at the end of this document.

***Urgent***

**Same day**

CRAO<12 hours old

Papilloedema

Retinal Detachment

Suspected Temporal Arteritis

Penetrating Injuries

Acute Glaucoma

Chemical Injuries

Orbital Cellulitis

Sight-threatening Keratitis

Corneal Injury

Endophthalmitis

**Same week**

Retinal Breaks & Tears

Rubeosis iridis

Pulsating Proptosis

Hyphaema

Hypopyon

Uveitis

Unexplained Sudden Loss of Vision

**If possible, ring the eye department first.**

**Fax the referral form to the eye department.**

**Alternatively, give the patient the form.**

**Send a copy to the GP.**

***Soon (within 1 month)***

Amaurosis Fugax

Central Serous Retinopathy

Diabetic Retinopathy-maculopathy

Diabetic Retinopathy - Pre-proliferative

Diabetic Retinopathy - Proliferative

CMV & Candida Retinitis

Vitreous Detachment with Symptoms and/or lowered IOP

Commotio Retinae

CRAO>12 hours old

CRVO with Elevated IOP

IOP>35mmHg

Macular Oedema

Early 'Wet' Macular Degeneration

Macular Hole

Retrobulbar / Optic Neuritis

Dacryoadenitis

Dacrocystitis

Inflamed Pingueculae

Scleritis

Episcleritis

Keratitis

Rubeosis

Incommitancies

Specific Field Defects

***Routine (within 3 months)***

Disc Cupping with Field Defect

Disc Cupping with IOP > 21mmHg

Glaucomatous Field Defects

IOP>/= 30mmHg and</= 35mmHg

IOP>5mmHg Difference between eyes

Optic Disc Pallor/Haemorrhage

Optic Disc Pits

Retinitis Pigmentosa

Retinoschisis

Suspected Choroidal Melanoma

Macular Degeneration that visually disables the patient

Acquired Ptosis

Basal Cell Carcinoma

Changed Melanosis of Lids / Conjunctiva

Conjunctival Cysts or Inclusions giving rise to discomfort

Ectropion

Entropion

Exophthalmos / Proptosis

Foster-Fuch's Spot

Lens Opacities that virtually disable the patient

Keratoconus

Hay-fever Conjunctivitis in Juveniles

Naso-lacrimal Duct Obstruction

Persistent Blepharitis

Persistent Conjunctivitis

Persistent Cysts (Meibomian/Zeiss/Moll glands)

Persistent Hordeolum

Pterygium threatening the Visual Axis

Pupillary Defects

Severe Dry Eye

Significant Corneal Dystrophy

***Optometrist Managed (not referred)***

Background Diabetic Retinopathy

Dry' Macular Changes with reasonable vision

Vitreous Detachment / Opacities without symptoms & lowered IOP

IOP>21 With normal discs & fields

Asteroid Hyalosis-no referral required

Early Lens Opacities

Hordeolum

Pingueculae

Pterygium not threatening the Visual Axis

Sub-Conjunctival Haemorrhage with normal BP

Superficial Foreign Bodies and Ingrowing Lashes

Meibomian Gland Dysfunction

Chronic Blepharitis

Chronic Dry Eye

Contact Lens Problems not involving Serious Corneal Infection

Early Fuch's Dystrophy with normal IOP

Early Map-dot-fingerprint Dystrophy

Hay-fever & Allergic Conjunctivitis in adults

Refractively managed Squint

Minor Non-specific Field Defects (in the absence of other signs)

Holmes-Aidie Pupil

***Refer to GP (for medical tests only)***

CRVO with normal IOP - Inform GP, may need BP check

Hollenhorst Plaques - Soon to GP / Risk of stoke?

Gross hypertensive Vessel Signs

Minor retinal haemorrhages (non-diabetics) may need BP/BS check

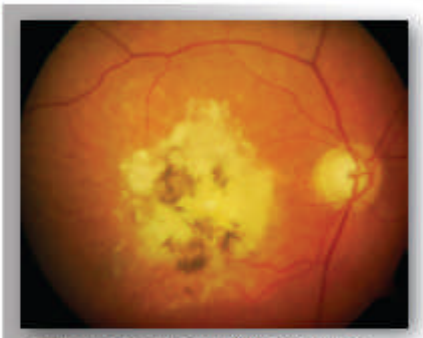
Migraine type symptoms

**Refer via GOS18 or headed notepaper**

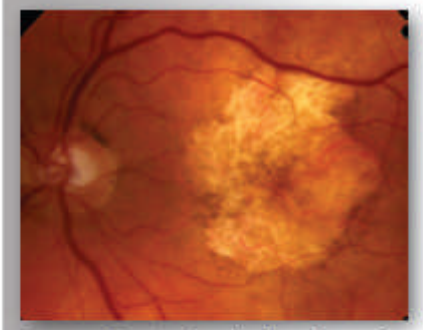
**Stress that referral to HES is not advised at present**

## Untreatable AMD

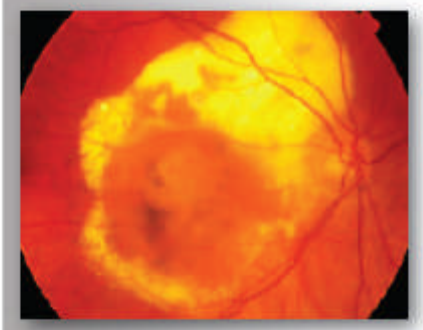
Routine referral for LVA assessment



Disciform Scar: Extensive subretinal fibrosis and pigment change at the macula. This shows advanced disease which is not appropriate for treatment.



Geographic atrophy: Another form of advanced AMD (Dry) showing extensive retinal atrophy / thinning at the macula. This patient is not suitable for treatment.



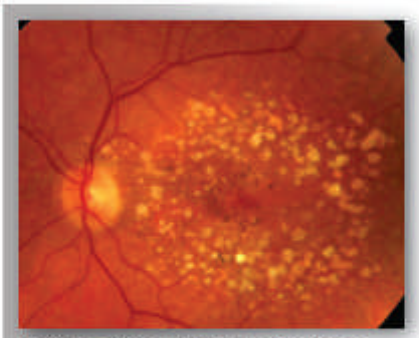
Advanced wet AMD - central macular elevation with/without subretinal fluid, hard exudate and some fibrosis. Visual acuity worse than 6/60. Not appropriate for treatment.

These patients may require a hospital assessment on a non-urgent basis.

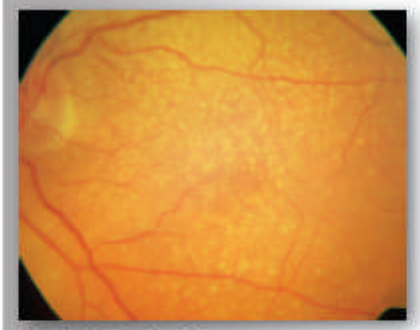
They may benefit from LVA assessment, visual impairment counselling and/or registration.

## Drusen

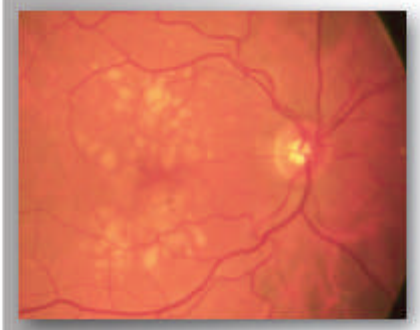
Refer only if fulfills guidelines on form



Multiple drusen and pigment change.



Multiple fine hard drusen.



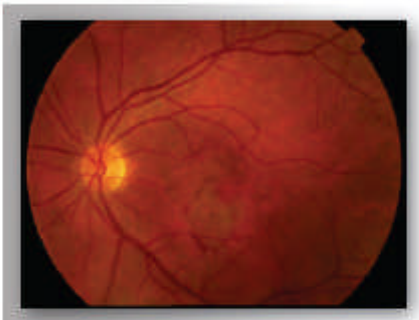
Large soft drusen.

These appearances are consistent with Age Related Maculopathy (ARM). Patients with drusen commonly notice distortion when shown an Amsler grid. This is less significant than spontaneously reported visual distortion.

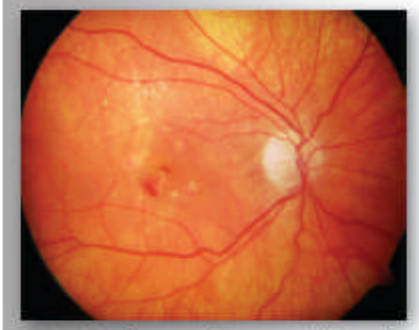
Only refer if patient has noticed sudden onset of distortion or blurring of central vision. If the patient smokes they should be encouraged to give up as smoking has been shown to be a risk factor in the development of AMD. These patients may benefit from anti-oxidant supplements.

## AMD

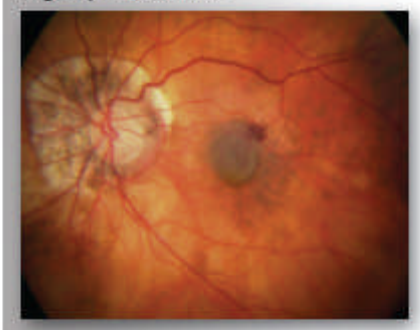
Refer if fulfills guidelines on form



Subretinal haemorrhage and subretinal fluid suggest choroidal neovascularisation. This patient requires urgent referral and assessment if VA in this eye is 6/60 or better.



Intraretinal haemorrhage centrally and exudates deposition superiorly. There may be associated subtle subretinal fluid or thickening. The presence of exudates is an important sign of leakage from choroidal neovascularisation. Refer urgently if VA is 6/60.



Small areas of intra / sub retinal haemorrhage amongst the drusen suggest choroidal neovascularisation. This patient requires urgent referral and assessment if the VA in this eye is 6 / 60 or better.

Blood, retinal swelling and exudates deposition at the macula suggest wet AMD requiring urgent referral.

Please refer according to local protocols or use the attached form and fax to the appropriate consultant.

This form may also be used for choroidal neovascularisation which is not in the context of AMD eg Myopia.