Urgency of the condition

This table has been developed as a tool to assist with ophthalmology referrals. However diagnoses are not absolute and if there are atypical features please contact the triage nurse for advice regarding referral.

Please phone the triage desk Monday to Friday between 08.30 and 16.30 (PAEP) or 9.00 to 17.00 (St John's). If you have an emergency/urgent query out with these hours contact the on call ophthalmologist through the RIE switchboard.

Emergency – same day

Urgent – <1 week

Soon – 1-3 weeks

Routine – 6-8 weeks

Emergency referrals include: retro-orbital haemorrhage, acute angle closure glaucoma, penetrating eye injury and severe chemical injury.

Condition	**How Soon**	**Additional Information**
Painful red eye		
Angle closure glaucoma	Emergency	
Iritis	Urgent	
Scleritis	Urgent	Consider oral NSAID
Episcleritis	Routine	Consider oral NSAID
Keratitis – bacterial, HSV, marginal	Urgent	
Corneal ulcer	Urgent	
Recurrent erosion syndrome	Urgent	Regular lubricants
Trauma		
Corneal foreign body	Urgent	Attend optometrist/accident and emergency for removal. If unsuccessful refer to ophthalmology
Blunt trauma	Urgent	
Penetrating eye injury/globe rupture	Emergency	
Chemical injury	Emergency	Immediate irrigation in primary care by

		GP/optometrist/A and E
Retro-orbital haemorrhage	Emergency	
Eyelid laceration	Urgent	
Corneal abrasion	Urgent	Manage in primary care. Use of lubricants following the abrasion is important to prevent recurrent erosion syndrome.
Welders flash	Urgent	Consider optometrist management
Non-painful red eye		
Subconjunctival haemorrhage	Routine	Need not be referred unless recurrent. These can take a few weeks to resolve. Are they on warfarin/anticoagulants?
Dry eye	Routine	Manage in primary care. Regular lubricants
Conjunctivitis – viral, allergy, bacterial	Routine	Need not be referred. Could be managed in community
Lid swelling/involvement		
Pre-septal cellulitis	Urgent	Need not be referred. Could be managed in community
Orbital cellulitis	Emergency	See section on orbital cellulitis
Dacrocystitis	Urgent	See section on dacrocystitis
Herpes Zoster Ophthalmicus	Urgent	Need not refer unless eye is involved (red, painful, decreased vision).
Ectropion, entropion	Routine	Routine plastics clinic Refer if patients would consider surgical treatment
Suspected SCC/BCC	Urgent	
Chalazion/cyst	Routine	Need not be referred unless recurrent/not resolving and patient would consider surgery. Regular lid hygiene measures as initial management
Blepharitis	Routine	Lid hygiene
Neuro- ophthalmology		
Temporal arteritis	Urgent	Refer to ophthalmology only if visual symptoms are present otherwise referral is to Rheumatology. Start oral prednisolone.
Nerve palsy without red flags (see diplopia algorithm)	Routine	See also diplopia
Optic neuritis	Urgent	

Disc swelling/ suspected idiopathic intracranial hypertension	Urgent	Consider optometrist assessment
Pre-existing/worsening adult squint	Routine	Refer if would consider surgery
Other Retinal pathology		
Hypertensive retinopathy	Routine	Please also refer to GP for measurement/management of blood pressure
Naevus – typical – atypical	Routine Urgent	
Suspected melanoma	Urgent	
Acute vision loss		
Vein/artery occlusions	Urgent	Please address cardiovascular risk factors
Retinal detachment	Emergency	
Wet AMD and vision better than 6/60 in affected eye	Urgent	
Macular/disc haemorrhage	Urgent	
Central serous retinopathy	Routine	
Cystoid macular oedema	Urgent	
Flashes floaters		
Vitreous haemorrhage	Urgent	Please address diabetic control.
Posterior vitreous detachment	Urgent	Can often see optometrist initially
Retinal tear/hole	Urgent	
Gradual loss of vision		
Cataract	Routine	Please ensure patients have a cataract assessment completed by a local optometrist prior to referral
Posterior capsular opacification	Routine	
Dry AMD	Routine	
Diplopia		Please describe and highlight whether vertical/horizontal or monocular/binocular
Diplopia + headache/ ptosis/abnormal pupil	Urgent	Consider referral to A and E if you suspect a posterior communicating artery aneurysm
Diplopia < 50 years	Urgent	

Diplopia > 50 years	Routine	
Diplopia + trauma	Urgent	
Chronic diplopia	Routine	Could be referred to optometry as cataract can cause chronic diplopia
Paediatrics		
Cataract in a child	Urgent	
Suspected retinoblastoma	Urgent	
Neonatal conjunctivitis (within 28 days of birth)	Urgent	Refer to secondary care (Sick Children's)
Acute reduction in vision	Urgent	
Squint – <3 years of age refer to ophthalmology >3 years refer to optometrist	Routine	
Diagnosis of permanent sensorineural/conductive hearing loss	Routine	See paediatric referral section
Children with Down's syndrome	Routine	Refer for vision assessment between 18 months to 2 years
Intermittent visual loss		
Migraine	Routine	Need not be referred
Amaurosis fugax	Urgent	Referral to neurovascular service if symptoms resolved
Diabetes		
Proliferative retinopathy	Urgent	Manage diabetic control and risk factors
Maculopathy	Routine	
Glaucoma		With optic disc cupping + visual field loss
Acute angle closure	Emergency	
IOP >34mmHg	Urgent	
IOP 29-34mmHg	Urgent	
IOP <28mmHg	Routine	
Ocular Hypertension		With no evidence of optic disc changes or visual field loss
>40mmHg	Urgent	

35-40mmHg	Urgent	
<35mmHg	Routine	
Post-operative		
Infection – suspected endophthalmitis	Urgent	
Inflammation	Urgent	
Thyroid Eye Disease		
If optic nerve involvement	Urgent	
If no optic nerve involvement	Routine	