# UHL Ophthalmology Triage Tool (2024)

Eye Casualty opening hours: Mon to Fri 8.30 to 16.30, Weekends & Bank Holidays : 8.30 to 12.30 Out of these hours, patients with immediate emergencies should be sent to main A&E. For advice and guidance, please contact Eye Casualty reception on **0116 2586273**

| | **Emergency (Same Day)**<br>**Please send the patient to eye casualty with a copy of referral letter** | **Urgent Referrals**<br>**(Between 48 hours and 2 weeks)**<br>**ophthalmleyecasualty@uhl-tr.nhs.uk** | **Non Urgent Referrals (soon/routine)**<br>**Greater than 2 weeks**<br>**(Use Cinapsis pathway)** |
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| **Visual** | • Sudden onset flashes & floaters with risk factors* (Myopia > 6D, previous RD, RT)<br>• Sudden onset of neurological visual field defect<br>• Sudden onset diplopia<br>• Sudden persistent or intermittent LOSS (not blurred) of vision (excluding ocular migraine) | • Sudden onset of flashes & floaters without risk factors<br>• Unexplained gradual vision loss < 4 weeks | • Cataracts should be referred via the local pathway wherever possible<br>• Suspected Paediatric Amblyopia or squints<br>• Recurrent corneal erosion syndrome unresponsive to topical medication<br>• Chalazion unresponsive to treatment and suitable for excision<br>• Suspect glaucoma, IOP >23mmHg, Optic Nerve Head changes, Visual field defects characteristic of glaucoma<br>• Asymptomatic retinal pathology including peripheral degeneration and retinal naevus |
| **Anterior segment** | • Blunt, penetrating or chemical Injury<br>• Recent severe painful (>=8/10) red eye with or without photophobia (not irritation)<br>• IOP > 40mmHg with suspicion of AAC (VH angle 1 or less)<br>• Post-operative severe pain < 3 weeks (to go to provider)<br>• Hypopyon - Endophthalmitis<br>• Orbital Cellulitis suspected (2 or more features)<br>• Herpes Zoster Ophthalmicus with ocular involvement with Hutchinson sign*<br>• Anisocoria new onset with associated acute ptosis or abnormal ocular motor balance<br>• Acute proptosis unilateral with periorbital pain | • Large non-resolving corneal abrasions<br>• Corneal Foreign body<br>• IOP > 40mmHg<br>• Mild to moderate ocular pain with a history of uveitis<br>• Mild to moderate ocular pain with a history of HSK<br>• Post-operative mild-moderate pain<br>• Post-operative persistent uveitis<br>• Swollen eyelid without suspicion of Orbital cellulitis (excluding chalazion/blepharitis)<br>• IOP 30 to 40 mmHg<br>• Narrow van herick anterior chamber angle grade 1 with symptoms<br>• Conjunctivitis unresponsive to treatment<br>• Episcleritis unresponsive to treatment<br>• Post-operative cataract complications > 3 weeks (to go to provider)<br>• Anisocoria incidental finding without any other features | |
| **Posterior segment** | • Visible retinal detachment, tears or breaks<br>• Vitreous haemorrhage without history of diabetic retinopathy<br>• New onset of confirmed Retinal artery occlusion to rule out GCA | | |
| **Other** | • Suspected bilateral disc oedema with new headaches and reduced vision<br>• Temporal headache with acute vision loss (NOT blurred vision) in patients over 50 years old with or without jaw claudication and scalp tenderness | • Suspected optic disc swelling with NO symptoms of raised Intra Cranial Pressure & NO visual field defect<br>• Suspected periocular malignancy (Will be referred to Oculoplastics via urgent pathway) | **Exclusions Consider referral directly to GP* or A&E****<br>• Temporal headache without acute vision loss in patients over 50 years old with or without jaw claudication and scalp tenderness*<br>• Herpes Zoster Ophthalmicus without ocular involvement with Hutchinson sign*• Headaches without ocular involvement*<br>• Acutely unwell adult or child with ocular symptoms including pyrexia and swollen eyelids (remove)**<br>• Thunderclap headaches** |