Dudley Referral Guidelines for Optometrists

Issued and approved **by:**

Dudley Group NHS Foundation Trust
Dudley Clinical Commissioning Group
Dudley Local Optometric Committee

Updated: 26th January 2021

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This guidance summarises the Dudley local protocol for ophthalmology referrals from Optometrists.

Practitioners should use their professional judgement and they should recognise their limitations and where necessary seek further advice or refer the patient elsewhere.

Part 1. Pathways

1. Emergency Referrals - That Day – Telephone Hospital

Please consult Part 2, Urgency of Referral Guidelines by Condition, for the appropriate Referral Destination as Russells Hall does not manage all Emergency Conditions.

Russells Hall Hospital (RHH)

Eye Department, Ground floor, north wing, Pensnett Road, Dudley, West Midlands, DY1 2HQ

Contact the eye casualty triage in the Emergency Referral Clinic; Tel 01384 456111 ask for Ophthalmic Triage Bleep or X 3633.

Discuss your findings and follow advice. Give the patient a completed Urgent referral form (or CUES referral form) to take to the Urgent Referral Centre (URC) (can also be Faxed to 01384 244560)
Send a report of your actions to their GP

NB. There is no walk in Eye Casualty Service at Russells Hall. If this is required direct the patient to BMEC or Wolverhampton.
Eye Triage in the Emergency Referral Clinic is available weekdays 9am to 4pm

If out of hours or for a condition not managed by Russells Hall

Birmingham & Midland Eye Centre (BMEC)

City Hospital, Dudley Road, Birmingham B18 7QH

Contact the eye casualty triage nurse on: 0121 507 4440
The triage nurse will discuss with you whether the patient should be sent immediately or next day and an appointment time will be offered to the patient. You should give the patient a short written referral letter for them to present on arrival in the eye casualty department.
Send a report of your actions to their GP

Casualty is open Monday to Friday 09.00 until 19.00 – Saturday 09.00 until 18.00. Outside these hours patients should attend their local hospital casualty department.

For Wolverhampton CCG Patients or those closer to Wolverhampton

Wolverhampton Eye Casualty at Emergency Referral Unit

New Cross Hospital, Wolverhampton Road, Wolverhampton, WV10 0QP

Emergency - Call Wolverhampton Eye Hospital (01902 695805) and discuss findings.
Send patient with referral form or a completed MECS referral form
or Fax to 01902 695842 or Email to rwh-tr.optometry-referrals@nhs.net
Send a report of your actions to their GP

A walk in service is available weekdays 8am-5pm and weekends 8am-4pm
Please follow the Wolverhampton Protocol at http://wolvesloc.net/practitioners/referral-guidelines/

2. Urgent Referrals Pathway

Please consult Part 2, Urgency of Referral Guidelines by condition, for the appropriate Referral Destination as Russells Hall does not manage all Urgent Conditions.

For BMEC or Wolverhampton please contact them following the Emergency guidance.

For Russells Hall Urgent referrals are sent to the Urgent Referral Centre (URC) for Triage.

Urgent referrals must be sent to the GP practice on the Urgent Referral Form (see Appendix) where they are entered on to the Electronic Referral Service for sending to the URC.

Please consult the clinical Management Guidelines and ensure as much information as possible is entered onto the urgent referral form to ensure appropriate management.

1) **Complete the Urgent Referral Form** (see Appendix) with the patient present and ensure all aspects of history and symptoms are recorded.
2) **Give the Urgent Referral Form to the patient** and instruct the patient to take it immediately to their GP surgery and request the practice to transmit the form that day to the URC.
   N.B. the ERS entry form is likely to be completed by a non-medical member of staff so the Optometrist should ensure any writing on the form is clearly legible.
3) The URC will Triage and contact the patient in due course (usually that day) to arrange an appointment in a timescale recommended by the consultant based on the information provided on the form.

For Optometrists who have NHSMail accounts the Urgent Referral Form can be sent to the GP via NHSMail. Always contact the GP practice first to ensure the correct NHSMail address for the GP practice.

N.B. Optometrists must not cause undue concerns for patients by indicating a timescale for their appointment as this will be decided by the consultant based on the information on the referral.

Outcomes from the Referral will be sent to the GP and the patient, so if the Optometrist requires feedback it is recommended to ask the patient to share their letter.

- The CUES service has its own Urgent Referral Pathway

3. Routine Referrals Pathway – all via GP - (No Direct Referrals)

All routine referral s are via GP and must be on the new GOS18 form (see Appendix)

Onward referrals to the HES are likely to be via "Choose and Book" (CaB). This system provides two ways for a GP surgery to find an appointment in the correct service (e.g. clinic). These are via "Clinic Type" or via a "Clinical Term". Please note that the person doing this booking may not be a doctor.

1. Priority is to complete "Clinic Type" - Tick just one – the most urgent

N.B Ensure you complete the correct Adult or Child section. Adults are 16 or over.

- These Clinic Types are fixed and are the same throughout England.
- When a Clinic Type is entered on CaB all the services linked to it are displayed. For a simple one (such as Cataract) this will show all the clinics seeing cataracts and nothing else.
- Other Clinic Types may result in a range of different clinics being offered. However these clinics may only see a subset of the conditions covered by the Clinic Type. For instance Oculoplastic / Orbit / Lacrimal may link to a nurse led cyst service, a lid malposition (entropion etc) service or a service exclusively for lacrimal problems.

If a range of different types of clinic are offered the GP surgery will need to select the correct one. They can do so on the basis of a "Clinic Term" you have entered (see below) and/or the additional information you put on the free text part of the form.

2. Then Complete "Clinical Term" – enter as many as is appropriate

Enter as many clinical terms (such as "Entropion") in the search field. In CaB this will show all the services which see patients with this problem or diagnosis.

This is particularly useful for conditions that the GP may not recognise, such as "Keratoconus" or "Macular Dystrophy"

You must provide both a Clinic Type and Clinical Term for all patients.

For Optometrists who have NHSMail accounts the Urgent Referral Form can be sent to the GP via NHSMail. Always contact the GP practice first to ensure the correct NHSMail address for the GP practice.

- The CUES service has its own Routine Referral Pathway

4. Coronavirus Urgent & Emergency Service (CUES) Pathway

The Service provides initial contact, telephone triage, remote consultations and where necessary face to face assessments and management of recent onset symptomatic or urgent ocular presentations.
The Service will maintain a minimum number of face to face patient interactions by adopting remote consultation by the most appropriate clinician, triage to the most appropriate clinician if a face to face appointment is necessary and optimising each consultation with ophthalmologist, or optometrist with independent prescribing advice & guidance, where appropriate.
Initial telephone contact and access to clinical triage – access to the Service is restricted to telephone booking only, to identify people with Covid-19 symptoms, at risk /self-isolating people to signpost to appropriate services.
Telephone/ video consultation offered and selfcare advice or provide signed orders remotely, where appropriate.
Face to face appointments with optometrist following telephone/video consultations for those who are presenting with urgent and higher risk symptoms (observing PPE guidance and social distancing advice)
Routine referrals are managed via the OPERA IT Platform. Emergency and urgent referrals follow the above guidance and are managed by the service through their own pathways agreed with the Eye Departments.

5. Wet AMD Pathway

(Especially if new and vision better than 6/96)

Suspect Wet AMD should be referred to Russells Hall Hospital urgently by FAX to 01384 244880.

To protect yourself you should confirm receipt by phoning 01384 244812.

These numbers are monitored Monday to Friday 8.15am - 4.15PM

The referral should be made on a Dudley Wet AMD Fast Track Form (see appendix) and notify GP

It is important you follow this pathway for suspect Wet AMD as if you don't, and the patient is not seen with due urgency, you could be considered negligent.

The Macula clinic contact advice for patients is available on their eye clinic letters and documents.

For the latest numbers please see the Ophthalmology Department's web page at http://dudleygroup.nhs.uk/services-and-wards/ophthalmology/

For Optometrists who have NHSMail accounts:

The Dudley Wet AMD Fast Track Form can be sent to: dgft.ophthalmologyurc@nhs.net

Notifications sent to the GP via NHSMail - Always contact the GP practice first to ensure the correct NHSMail address for the GP practice

6. Cataract Referrals Pathway

All Cataract referrals should be via the Pre-Op Direct Referral Service Routine and are via the Optomanager Platform.
The service requires you to provide assessment and management of patients presenting with signs and/or symptoms of cataract in either eye. An additional fee is paid by the CCG for the extra work.

The Protocol is:

1. Routine Sight test reveals the presence of a Cataract.
2. Ensure the patient meets current Dudley EBI eligibility criteria:
    a. The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse although Cataracts causing glare or starburst effect when driving, will be considered even if the visual acuity is better than 6/9) AND
    b. Should affect the patient's lifestyle
    c. Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc.
    d. Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground.
    e. Ability to work, give care or live independently is affected
    f. Only assess and refer patients under this service who are NOT already under the care of an NHS Trust ophthalmologist for another active ocular condition. To refer these patients, write directly to the patient's consultant at the trust.
    g. Patients want to have surgery and consents to referral
3. Cataract assessment to include:
    a. Pupil dilation and examination by indirect ophthalmoscopy in order to establish whether there are any co-existing ocular disorders as well as cataract
4. Discussion of health questionnaire and any outstanding issues dealt with.
5. Communicating the potential advantages and disadvantages of cataract extraction
6. Ascertaining the patient's willingness for surgery
7. Offer Choice of provider
8. Complete the web based Optomanager record. Optomanager then will automatically send referral to chosen provider and copy to GP for information for patients with a Dudley CCG GP.

All information you need to print will be available via the Optomanager platform.

If you do not have access to the OptoManager Platform please contact the LOC.

Documents and the full service protocol can be downloaded from the LOC website.

Please note that this is the locally agreed pathway. In the future GPs may reject GOS18 referrals for cataract and will simply re-direct the patient to an alternative practice that provides Cataract Direct referral

7. IOP Repeat Readings Pathway

All patients with raised IOP at a sight test should go into the IOP Repeat Readings service. The prime purpose of IOPRR is to reduce onward unnecessary referrals to secondary care.

The service requires you to provide a Goldmann / Perkins applanation tonometry to patients with raised IOP. An additional fee is paid by the CCG for the extra work.

The service, commissioned by Dudley CCG and run by Primary Eyecare Services, is solely for the patients of Dudley CCG GPs. Patients with a Birmingham or Black Country CCG GP, may also be entitled to repeat readings referral but you need to be aware there may be some differences in protocol that you will need to follow.

The Protocol is:

1. Routine sight test reveals IOP >23mmHg.
2. Ensure patient meets the eligibility criteria:
    a. Patients registered with a Dudley GP or resident within Dudley.
    b. Patient aged 16
    c. Patient has no other ocular pathology requiring specialist referral.
    d. Patients not previously seen in the service within 6 months unless clinically appropriate.
    e. No other evidence of glaucoma, i.e. elevated IOP and/or optic disc changes and/or visual field defect.
    f. Patients Not already under the care of an ophthalmologist for Glaucoma , OHT or suspected Glaucoma.
3. Patients found to have elevated IOP by NCT (>23mmHg) are expected to have Goldman/Perkins at the same visit.
4. If further readings are necessary follow up appointments should take place within two weeks.

Routine referrals are made via Optomanager automatically from the IOPRR software. In all consultations a report is generated to the GP. There are text boxes you can provide more detailed information.

Please consult the guidance provided by Primary Eyecare Services or use he help function on the platform. Urgent & Emergency Referrals should follow the appropriate pathway

Part 2. Urgency of Referral Guidelines by condition

The following list of conditions is not exhaustive, but contains many conditions presenting in primary care. The Conditions are listed in column one alphabetically under each referral category.

The second column contains a College of Optometrists Clinical Management Guidelines (CMG) referral category code. If a code is present, practitioners should consult the CMG for management advice and guidance. Please Note: Many conditions have varying degrees of severity and therefore referral urgency. In these cases the CMG will help determine severity and urgency

The third column shows the usual location to direct the referral. This could be a local or more specialist Eye Clinic, GP, Coronavirus Urgent & Emergency Service (CUES), the IOP Repeat Readings Service (IOPRR) or the Cataract Direct Referral Service (CDRS). If the column is blank, assume Russells Hall Hospital.

The College of Optometrists guidance for referrals is quite comprehensive and all Optometrists are advised to follow this. It states in paragraph C184:
You must refer patients with appropriate urgency. If there are local protocols in place for referrals, including emergency or urgent referrals, you should follow these. If in doubt, you should seek advice from the on-call ophthalmologist to determine the most appropriate pathway for the patient. Where there are no local protocols, guidance on which conditions are considered an emergency and which are considered urgent can be found in para C205a and C205b.

This guidance is intended to be the local protocol for ascertaining the urgency of a referral and where there is no specific guidance the College of Optometrist Guidance would become the default position. The College of Optometrists Referral categories have therefore been added where available .

They are:

A1 - Sight-threatening Conditions - Immediate Referral to Ophthalmologist without Intervention

A2 - Sight-threatening Conditions - First Aid Measures and Urgent Referral

A3 - Sight-threatening Conditions - Urgent (within 1 week) referral to an ophthalmologist

B1 - Conditions not normally Sight-threatening - Possible prescription of Drugs, Routine Referral

B2 - Conditions not normally Sight-threatening - Alleviation or Palliation. No Referral

B3 - Conditions not normally Sight-threatening - Management to Resolution

Emergency referral (That Day), symptoms or signs suggesting:		
3rd Nerve palsy with pupil involvement		A&E if pain
Acute Angle Closure Glaucoma	A2/3	
Acute Dacryocystitis in children, or in adults if severe (e.g. Fever)	A2/3/B1/3	
Acute Ptosis with Motility disorder		
BRAO – Acute		
CL induced corneal infection (Microbial Keratitis)	A1	RHH
Cellulitis (preseptal or orbital)	A1	
CRAO - Acute <12hrs		
Corneal Graft infection/rejection (oedematous graft)/reduced vision	A1	RHH
Corneal foreign body penetrated into stroma, or with presence of a	A2	RHH

rust ring (unless specifically trained in rust ring removal)		
Canalicular laceration		
Endophthalmitis (post- operative)	A1	
Eyelid lacerations		
Horner's - Acute (exclude life threatening complications)		
Hyphaema		
Hypopyon		
Herpes simplex keratitis – (first time finding)	A1 /B2	
Herpes Zoster ophthalmicus with acute skin lesions (emergency referral to GP for systemic anti-viral treatment with urgent referral to ophthalmology if deeper cornea involved)	A1/3 B3	Emergency to GP & RHH
Keratitis – Infectious, microbial or sight threatening	A1	
IOP > 40mmHg (by GAT & independent of cause)		IOP RR to RHH
Ophthalmia neonatorum	A1	
Papilloedema - high suspicion and not just blurred disc margins		A&E if symptoms
Periorbital infection with skin necrosis (necrotizing fasciitis)		
Postoperative infection / Wound Leak / broken transplant suture	A1	
Pre Retinal Haemorrhage/Vitreous Acute Haemorrhage		BMEC / WEI
Retinal Breaks and Tears		BMEC / WEI
Retinal Detachment		BMEC / WEI
Rubeosis		
Scleritis () Necrotising	A2	
Sudden Severe Ocular Pain especially associated with vision loss		
Sudden Loss of Vision - Unexplained		
Temporal Arteritis - Suspected GCA visual loss, disc swelling, headache		
Trauma - Chemical	A2	
Trauma – Penetrating or Fracture	A2	
Uveitis – (first time finding)	A1/3 B1/2	
Vitreous haemorrhage		
Vitreous Detachment Symptoms with pigment in the Vitreous – Shafer's sign / tobacco dust		
Viral conjunctivitis if severe e.g. presence of pseudomembrane or keratitis (severe pain or visual loss)	A2 B2	RHH

URGENT – via GP to Urgent Referral Centre symptoms or signs suggesting:

3rd Nerve palsy without pupil involvement		
4th Nerve palsy– (first time finding)		
6th Nerve palsy– (first time finding)		
Acute Paediatric Ptosis		
Amaurosis Fugax - include GP for urgent embolic investigation and ESR/CRP		RHH & GP
Anterior Uveitis - known		
Atopic keratoconjunctivitis with corneal epithelial macro-erosion or plaque	A3 to B1	
Bell's palsy – Onset with 72 hours and loss of corneal sensation	A2/B2/B1	GP/RHH
Blebitis –suspected		
Blepharitis - unilateral if meibomina gland carcinoma suspected	A3 B1/2	
BRVO		
Central Serous Retinopathy		
Choroidal Melanoma or High Risk / Elevated Naevus	A3	

Commotio Retinae		
Conjunctival Melanoma – where suspected elevated neavus	A3	
Conjunctivitis, Chlamydial	A3	GP /RHH
Corneal Hydrops if Vascularisation Present	A3 B2	RHH
CRAO>12 hrs old		
CRVO (If IOP ≥ 40mmHg by GAT refer as emergency)		
Dacrocystitis – Acute (see Emergency for children or if systemically unwell)	A2/3 B1/3	
Dacryoadenitis		
Diabetic maculopathy		
Diplopia – sudden onset		
Dry Eye – severe with rheumatoid arthritis or SJS or OCP suspected.	A3	
Eyelid neoplasia		Oculoplastics team
Herpes simplex keratitis - known		
Herpes Zoster ophthalmicus with deeper corneal involvement – emergency referral to GP for systemic anti-viral treatment	A3	Emergency to GP & RHH
IOP>30 mm Hg and <40mmHg by GAT		
Incomitancy – (first time finding)		
Lacrimal sac mass - non-compressible		
Macular Hole <12 months old		BMEC or Wet AMD pathway if unsure
Macular oedema		
ocular rosacea with severe keratitis	A3	
Post-operative suture breakage / lens dislocation– discuss with HES before referring	A3	
Proptosis with corneal exposure		
Retinoblastoma		Paediatric Service
Retinopathy		
Proliferative Diabetic Retinopathy		
Retrobulbar/Optic Neuritis		
Scleritis		
Squamous Cell Carcinoma		
Transient Ischaemic Attack		
Trauma – Blunt	A2	
Trichiasis with corneal fluorescein staining	B1/B2	
vernal keratoconjunctivitis with active limbal or corneal involvement	A3	
Viral keratoconjunctivitis		
Visual Field Defect suggesting urgent Neurological Investigation		
“Wet” Macular Degeneration – see wet AMD Pathway		Macular Clinic at RHH

ROUTINE – via GOS18 to GP or to CUES: symptoms or signs suggesting:		
Adult Ptosis		
Asteroid Hyalosis/Synchisis Scintillans(Confirm Diagnosis)		
Argyll Robertson (Confirm Diagnosis exclude complications)		
Basal cell carcinoma (BCC) (periocular)	B1	
Bell's palsy – Recovering & established cases (see Urgent for new cases)	B1/2	
Blepharitis - (B1 or B2 if required after CUES assessment)	B1/2	
Chalazion if recurrent / causing astigmatism / cosmetically unacceptable	B1	
Choroidal naevus – " Low-risk"	B2	
Chronic proptosis without corneal exposure/visual dysfunction		
Concretions / Conjunctival cysts or Inclusions giving rise to Discomfort	B3	
Conjunctivitis – Allergic (Inc Hayfever conjunctivitis in juveniles)	B1/2	
Conjunctivitis – Bacterial	B3	
Vernal conjunctivitis	B1/2	
Conjunctivitis – Viral – non severe (see Emergency for severe)	B2	
Conjunctivitis medicamentosa	B2	
Dacryocystitis (chronic) (see Urgent for Acute)	B1/2	
Diplopia - Gradual onset		
Disc Haemorrhage		
Dry eye (see urgent if RhA, SJS or OCP suspected)	B1/2	
Dry macular degeneration that visually disables the Px for Registration		
Ectropion – see Keratitis if significant exposure	B1/2	
Entropion -	B1	
Epiphora with blood stained tears		
Epiretinal membrane - if symptomatic or reduced vision		
Episcleritis	B2/3	
Exophthalmos/Proptosis		
Foreign Body – Superficial Corneal or Subtarsal	B3	
Floppy eyelid syndrome		
Fuchs Endothelial Corneal Dystrophy (FECD)	B1	RHH
Holmes-Adies (Confirm Diagnosis and rule out complications)		
Hollenhorst plaques		GP
Hordeolum	B2	
Horner's (Suspected new finding to exclude complications)		
Hypertensive Vessel Signs (and Diastole of >100 mm Hg to GP)		
IOP >24mm Hg and <30mm Hg (see page 10)		IOP RR to RHH
IOP > 5mm Hg difference between eyes with no other abnormal findings		IOP RR to RHH
Keratitis (marginal)	B3	
Keratitis, CL-Associated infiltrative (non infective)	B2	
Keratoconus		
Lattice degeneration – with atrophic round holes but no tears		
Lens opacities, which visually disable Px		
Melanosis of lids -Changed		
Molluscum contagiosum	B1/2	
Naso-Lacrimal duct obstruction	B1/2	
Pre-Proliferative Diabetic Retinopathy		

Ocular Migraine		GP
ocular rosacea (see urgent if severe keratitis)	B2	
Optic disc pallor		
Optic disc pits		
Persistent conjunctivitis		
Persistent Meibomian, Zeiss and Moll Cysts		
Persistent epiphora with recurrent conjunctivitis		
Photokeratitis	B3	
Phthiriasis (pediculosis ciliaris)	B1	GP
Pigment Dispersion Syndrome		
Pinguecula	B2	
Previously undiagnosed field defects (repeatable)		
Pterygium inflamed/threatening the visual axis/active	B1	RHH
Pseudoexfoliation with raised IOP		
Ptosis		
Pupillary defects		
Recurrent corneal epithelial erosion syndrome	B1/2	
Retinal haemorrhage		
Retinitis Pigmentosa		
Retinioschisis		
Significant corneal dystrophy		
Suspicious cupping		
Subconjunctival Haemorrhage - recurrent - A1 if intracranial cause suspected)	B3 / A1	GP
Squints		
Trichiasis without corneal fluorescein staining		
Xanthelasma		GP

GOS18 Routine Ophthalmic Referral/Information for GP **Please use black ink to fill in this form**

Date of sight test ..... **Date of referral (if different)** .....

Optometrist/OMP Name and Practice Address

Post Code: _____ **Tel:** _____

NHS mail: _____

GP Name and Practice Address

Patient details

Title Gender M / F

Surname

Forenames

Address

Post Code _____

Telephone: _____

Date of Birth _____

NHS number (if known) _____

GP Action Required: (Also see "additional information below)

- ☐ This letter is for INFORMATION ONLY
- ☐ Patient asked to telephone/visit GP
- ☐ Patient sent to Eye Casualty
- ☐ Advise Referral to Eye Dept (URGENT)
- ☐ Advise Referral to Eye Dept(Routine)

CHILDREN (15 or under) CLINIC TYPE suggested, tick most urgent one

- ☐ Strabismus and Amblyopia
- ☐ Paediatric non-strabismus
- ☐ Orthoptic (only)

ADULT CLINIC TYPE suggested, tick most urgent one

- ☐ Cataract
- ☐ Cornea
- ☐ Diabetic Medical Retina
- ☐ External Eye Disease
- ☐ Glaucoma
- ☐ Laser (YAG capsulotomy)
- ☐ Low Vision
- ☐ Oculoplastics/ Orbits / Lacrimal
- ☐ Other Medial Retina (incl ARMD)
- ☐ Squint / Ocular Motility
- ☐ Vitreoretinal
- ☐ Not Otherwise Specified

CLINICAL TERMS(S):
Enter relevant keyword(s) (these enable the GP to find correct HES service)

_____

_____

_____

_____

	Sph	Cyl	Axis	Prism	Base	VA	Pinhole	Add	Near Vision	Previous corrected VA on (date)
Right										
Left										

	Right eye	Left eye	
Visual fields	Normal/enclosed (if abnormal)	Normal/enclosed (if abnormal)	
Optic Nerve heads	C:D	C:D	
Intraocular pressure Time:	mm Hg	mm Hg	Applanation/non contact/ Other

Additional Information Cycloglegic refraction ☐ Dilated fundus examination ☐

GOS 18 Part One – This must accompany and referral made to an Eye Department

STATEMENT: The reason for this referral has been explained to the patient or guardian who agrees to it. The patient or guardian also consented to information being exchanged between the Hospital Eye Service, Their General Medical Practitioner, and optometrist or ophthalmic medical practitioner (delete any not consented to). ✓

If appropriate, Guardian's name and address _____

Signed (optometrist/OMP) _____ GOC/GMC No _____

GOS18 Routine Ophthalmic Referral/Information for GP (REAR)

Optometrist Guidance

Most referrals to the HES are via "Choose and Book" (CaB). This system provides two ways for a GP surgery to find an appointment in the correct service (e.g. clinic). Please note that the person doing this booking may not be a doctor.

1. **Priority is to complete "Clinic Type" - Tick just one – the most urgent –**
   N.B Ensure you complete the correct Adult or Child section. Adults are 16 or over.

- These Clinic Types are fixed and are the same throughout England.
- When a Clinic Type is entered on CaB all the services linked to it are displayed. For a simple one (such as Cataract) this will show all the clinics seeing cataracts and nothing else.
- Other Clinic Types may result in a range of different clinics being offered. However these clinics may only see a subset of the conditions covered by the Clinic Type. For instance Oculoplastic / Orbit / Lacrimal may link to a nurse led cyst service, a lid malposition (entropion etc) service or a service exclusively for lacrimal problems.

If a range of different types of clinic are offered the GP surgery will need to select the correct one. They can do so on the basis of the "Clinic Terms" you have entered (see below) and/or the additional information you put on the free text part of the form.

2. Then Complete "Clinical Term" – enter as many as is appropriate

Enter as many clinical terms (such as "Entropion") in the search field. In CaB this will show all the services which see patients with this problem or diagnosis.

This is particularly useful for conditions that the GP may not recognise, such as "Keratoconus" or "Macular Dystrophy"

You must provide both a Clinic Type and Clinical Term for all patients.

For Urgent or Emergency Referrals Please use the Emergency / Urgent Referral Form

Ophthalmology Urgent Referral

Urgent Referral Clinic contact number for GPs 01384 456111 EXT 3633

Patient Details

NHS Number:	**To be seen on same day ☐ or 2 working days ☐**
Surname:	**Date of Birth:** **Age:**
First Names:	**Country of Birth:** ☐
Address:	**Home Telephone:** **Mobile Telephone**: **Work Telephone:**

GP Details	**Optometrist Details**
Referring GP Name:	**Optom Name:**
National Practice Code:	**Practice:**
Address:	**Address**
Telephone Number:	Phone:

History

Brief history:

Has the patient visited the eye clinic in the past? Yes ☐ No ☐

Has the patient had previous eye surgery? Yes ☐ No ☐ If Yes specify

Ocular history: Contact lens wearer ☐ Uveitis ☐ Glaucoma ☐ Episcleritis ☐
Corneal ulcers ☐ Cataract ☐ ARMD ☐

Ocular comments:

Ocular findings: Lid swelling ☐ Conjunctival redness ☐ Foreign bodies ☐
Proptosis ☐ Fluorescein uptake ☐ Red reflex ☐

Ocular findings comments:

Cornea status: Normal ☐ Abnormal ☐ Flourescein uptake overlying corneal abnormality ☐

Pupil status: Normal ☐ Abnormal ☐ RAPD ☐ Unequal sizes ☐

Eye movement: Normal ☐ Abnormal ☐

Symptoms

How quick were the onset of symptoms? Sudden ☐ Gradual ☐ Incidental ☐

Visual acuity: Right eye Left eye

Decrease in vision:	Nil / RE / LE / Both	For how long	Worsening ☐
Loss of vision:	Nil / RE / LE / Both	For how long	Worsening ☐
Pain:	Nil / RE / LE / Both	For how long	Worsening ☐
Redness:	Nil / RE / LE / Both	For how long	Worsening ☐
Discharge:	Nil / RE / LE / Both	For how long	Worsening ☐
Flashing lights:	Nil / RE / LE / Both	For how long	Worsening ☐
Floaters:	Nil / RE / LE / Both	For how long	Worsening ☐
Photophobia:	Nil / RE / LE / Both	For how long	Worsening ☐
Double vision:	Nil / RE / LE / Both	For how long	Worsening ☐
Lid swelling:	Nil / RE / LE / Both	For how long	Worsening ☐

Other symptoms:

Provisional diagnosis:

Ophthalmology Urgent Referral (REAR)

To the GP Surgery - This is an Urgent Referral to Ophthalmology from an Optometrist.

Please enter the information on an Urgent ERS for Ophthalmology and transmit same day.

For the Optometrist:

Please consult the Urgency of Referral Guidelines by Condition and ensure as much information as possible is entered onto the urgent referral form to ensure appropriate management.

- Complete the Urgent Referral Form with the patient present and ensure all aspects of history and symptoms are recorded.
- Give the Urgent Referral Form to the patient and instruct the patient to take it immediately to their GP surgery and request the practice to transmit the form that day to the URC.

NB the ERS form is likely to be completed by a non-medical member of staff so the Optometrist should ensure any writing on the form is clearly legible.

- The URC will Triage and contact the patient in due course (usually that day) to arrange an appointment in a timescale recommended by the consultant based on the information
  provided on the form.

NB
Optometrists must not cause undue concerns for patients by indicating a timescale for their appointment as this will be decided by the consultant based on the information on the referral.

Outcomes from the Referral will be sent to the GP and the patient, so if the Optometrist requires feedback ask the patient to share their letter.

WET AMD RAPID ACCESS REFERRAL FORM TO RUSSELLS HALL

Name of Consultant: Mr Shafquat / Mr Al Ibrahim / Mr Bhardwaj

Clinic Details: Tel; 01384 244812; Fax 01384 244880: By NHSMail to: dgft.ophthalmologyurc@nhs.net

PATIENT DETAILS

NAME: DOB: HOSPITAL NO: (If known)

ADDRESS:

CONTACT TEL NOS:

GP NAME: **GP SURGERY:**

OPTOMETRIST DETAILS:

NAME: PRACTICE:

GOC NO: ADDRESS:

TEL: FAX:

AFFECTED EYE: RIGHT: ☐ LEFT: ☐

PAST HISTORY IN EITHER EYE

PREVIOUS AMD RIGHT: ☐ LEFT: ☐

MYOPIA RIGHT: ☐ LEFT: ☐

OTHER RIGHT: ☐ LEFT: ☐

REFERRAL GUIDELINES

PRESENTING SYMPTOMS IN AFFECTED EYE (one answer must be yes, please mark the correct box with an 'X')
Duration of visual loss:

1. Visual Loss YES ☐ NO ☐
2. Spontaneously reported distortion YES ☐ NO ☐
3. Onset of scotoma (or blurred spot) in central vision YES ☐ NO ☐

FINDINGS Best corrected VA (must be 6/96 or better in affected eye)

1. Distance VA RIGHT: ☐ / ☐ LEFT: ☐ / ☐
2. Near VA RIGHT: ☐ LEFT: ☐
3. Macular drusen (either eye) RIGHT: ☐ LEFT: ☐

In the affected eye ONLY, presence of:

4. Macular haemorrhage (preretinal, retinal, subretinal) RIGHT: ☐ LEFT: ☐
5. Subretinal fluid RIGHT: ☐ LEFT: ☐
6. Exudate RIGHT: ☐ LEFT: ☐

Comments

ADDITIONAL COMMENTS:

Macular Disease Society

THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

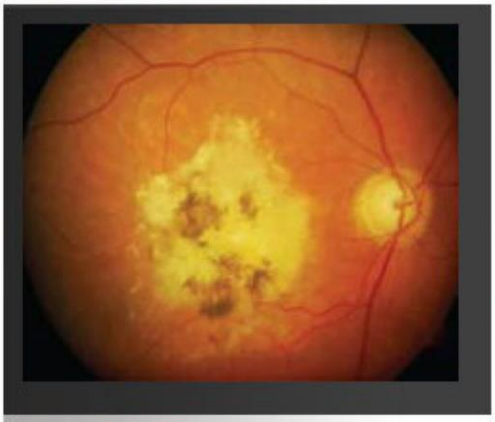
THE COLLEGE OF OPTOMETRISTS

RNIB

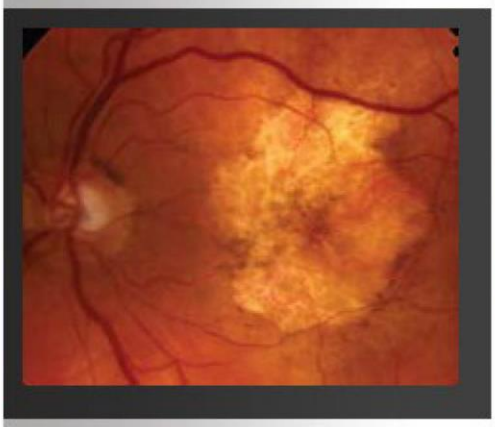
This form is intended for use by optometrists and general practitioners. It is based on the work of the Thames Valley Macular Group, namely: Susan Downes, Consuela Moorman, Lyn Jenkins and Sarah Lucie Watson. This group has audited the results of rapid access referral using this form and The Royal College of Ophthalmologists is keen to highlight and promote examples of good practice

Advanced AMD

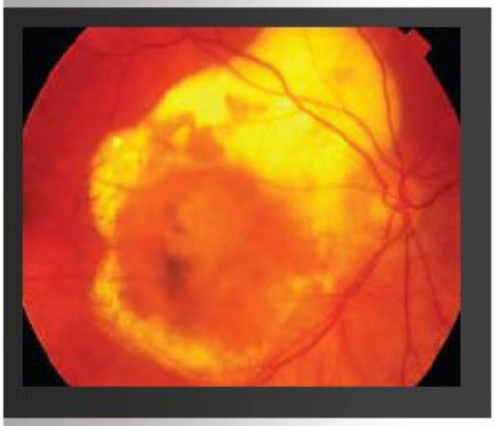
Refer if fulfils guidelines on form



Disciform Scar: Extensive subretinal fibrosis and pigment change at the macula. This shows advanced disease.



Geographic atrophy: Another form of advanced AMD (Dry) showing extensive retinal atrophy / thinning at the macula.



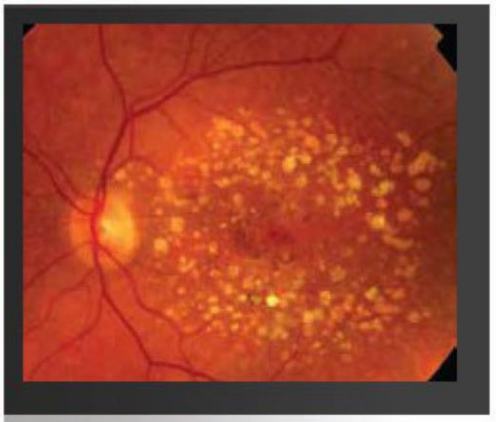
Advanced wet AMD - central macular elevation with/without subretinal fluid, hard exudate and some fibrosis.

If best corrected visual acuity is worse than 6/96, these patients may require a hospital assessment on a non-urgent basis.

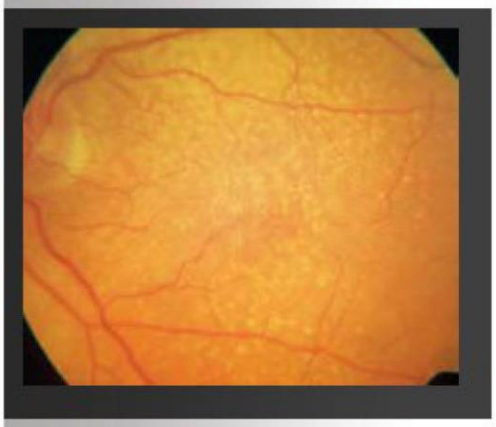
They may benefit from LVA assessment, visual impairment counselling and/or registration.

Drusen

Refer only if fulfils guidelines on form



Multiple drusen and pigment change.



Multiple fine hard drusen.

Large soft drusen.

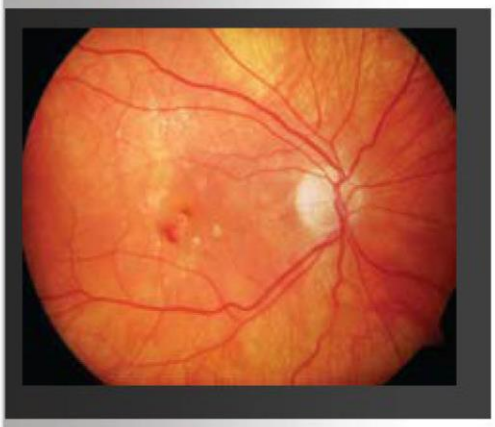
These appearances are consistent with Age Related Maculopathy (ARM). Patients with drusen commonly notice distortion when shown an Amsler grid. This is less significant than spontaneously reported visual distortion.

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 ocular nutritional supplements.

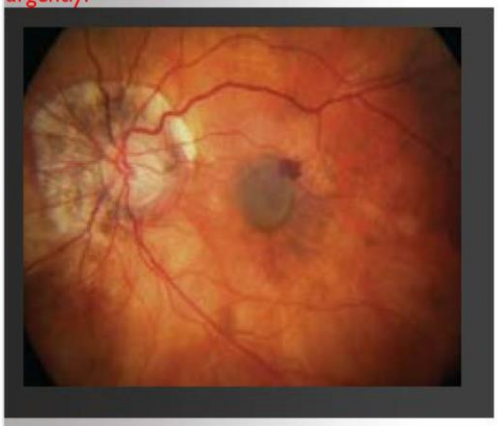
Wet AMD

Refer if fulfils guidelines on form

Subretinal haemorrhage and subretinal fluid suggest choroidal neovascularisation. **This patient requires urgent referral and assessment.**



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.



Small areas of intra / sub retinal haemorrhage amongst the drusen suggest choroidal neovascularisation. This patient requires urgent referral and assessment.

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.

REFERRAL GUIDELINES QUICK REFERENCE SUMMARY FOR OPTOMETRISTS IN DUDLEY

April 2021	**Emergency – That day** - Phone hospital for triage and send patient with Urgent Referral Form (or CUES referral form)		**Urgent/Soon – from 24hrs to 6 weeks** Send patient to GP surgery that day with completed Urgent referral form or CUES referral form		**Routine -** to GP or via GOS18 or CUES referral form
Anterior	**Red eye (non traumatic)** ● Acute Angle Closure Glaucoma ● Post-op/ infection / wound leak/hypopyon/ broken transplant suture ● Corneal graft rejection **Red eye (traumatic)** ● Chemical Trauma ● Penetrating injuries ● Stromal FB / Rust Ring ● Hyphaema	● Scleritis ● Infective keratitis ● Herpetic infection acute/new ● Uveitis ● Severe corneal abrasion ● Acute dacryocystitis ● Embedded foreign body ● CL induced Microbial Keratitis ● Eyelid/canalicular lacerations	● Iris rubeosis ● Marginal keratitis ● Anterior Uveitis – known ● Atopic keratoconjunctivitis ● Blebitis –suspected ● Conjunctival Melanoma ● Eyelid neoplasia ● Herpes simplex /Zoster – known ● Viral keratoconjunctivitis ● Dacryoadenitis	● Conjunctivitis, Chlamydial ● Dry Eye – severe with rheumatoid arthritis or SJS or OCP suspected ● Trichiasis with corneal fluorescein staining ● Squamous Cell Carcinoma ● Scleritis ● Corneal Hydrops with vascularisation	● Symptomatic en/ectropion / Trichiasis ● Chronic Exophthalmos/proptosis ● Persistent lid disease/cysts/hordeolum ● Lids / Ptosis / hoods / floppy ● Severe dry eye ● Pterygium (affecting visual axis) ● Persistent epiphora ● Keratoconus ● Recurrent corneal erosion syndrome ● Corneal dystrophies (reduced VA) ● Conjunctivitis allergic/persistent/viral /vernal / medicamentosa ● Naso-lacrimal duct obstruction ● Keratitis ● Episcleritis ● Xanthelasma
Visual Loss	● Temporal Arteritis ● Acute ocular pain with sight loss	● Sudden visual loss unknown cause (<24hrs)	● Amaurosis fugax ● Retrobulbar/Optic Neuritis	● Visual Field Defect suggesting urgent Neurological Investigation	● Gradual loss of VA >4weeks with no sudden loss ● Previously undiagnosed repeatable field defects
Posterior	● CRAO <12hrs ● BRAO - acute ● Rubeosis ● PVD with Shafers sign ● Endophthalmitis (post-operative) ● Horner's – Acute ● CRVO – IOP>40mmHg	● Floaters/photopsia <48 hours + tobacco dust ● Retinal tears & breaks ● Retinal detachment ● Papilloedema ● Vitreous haemorrhage	● BRVO ● Vitritis ● CRVO ● Myopic CNV ● Diabetic proliferative Retinopathy ● Nystagmus with other neurological signs ● Vitreous haemorrhage non-PVD)	● Central Serous Retinopathy ● Choroidal Melanoma or High Risk Naevus ● CRAO>12 hrs old ● Macular Hole <12 months old ● Macular oedema ● Diabetic maculopathy ● Wet AMD ● Retinoblastoma	● Diabetic maculopathy ● Retinal / Disc haemorrhages ● Suspect glaucoma/abnormal discs ● Dry AMD requiring registration/LVA ● Retinitis Pigmentosa ● Macular hole ● Epiretinal membrane ●Lattice degeneration – with atrophic round holes but no tears ●Retinioschisis
Other	● Orbital cellulitis ● Acute proptosis ● Acute Horners ● IOP >40 mmHg	● 3rd Nerve palsy with pupil involvement ● necrotizing fasciitis ● Ophthalmia neonatorum	● Suspected retinal cancers ● Suspected compressive lesion ● New pupillary defects ● Acute onset diplopia/ squint/ ● Acute Paediatric Ptosis	● 3rd / 4th / 6th Nerve palsy ● Bell's palsy – recent ● IOP>30 mm Hg and <40mmHg by GAT ● Incomitancy – (first time finding) ● Transient Ischaemic Attack	● Repeatable suspicious field defects ● Long standing squint requiring correction ● Children's manifest squint, amblyopia/reduced VA ● IOP >=24mmHg <30mmHg ● Diplopia gradual onset ● Pupil disorders non acute

Always check the full guidelines for the appropriate Referral Destination

This list is not exhaustive & practitioners should always apply their clinical judgement when deciding on the appropriate clinical pathway for a patient.

Making Referrals to Russells Hall Hospital in Dudley

Emergency – That Day	Urgent Referrals	Routine Referrals
Check the full referral guidance for appropriate destination	**Via GP** **NOT direct referrals**	**Via GP** **NOT direct referrals**
Phone the destination clinic and discuss findings and follow advice.	Urgent referrals must be sent on a Dudley Urgent Referral Form and sent via the Electronic Referral Service (ERS) from a GP practice	All routine referrals are via GP and must be on the new GOS18 form
Complete the Dudley Urgent Referral Form Give the patient the completed form to take to the agreed Referral Centre Send a report of your actions to their GP	1. Complete the Urgent Referral Form with the patient present. 2. Ensure all aspects of history and symptoms are recorded. 3. Give the Urgent Referral Form to the patient 4. Instruct the patient to take the form to their GP surgery immediately 5. Ask the patient to request the GP practice to transmit the form that day to the URC.	Onward referrals from the GP to the HES are via "Choose and Book" (CaB). All Optometry referrals must contain sufficient information to enable a GP surgery to find an appointment in the correct clinic. Please note that the person doing this booking may not be a doctor **Ensure a "Clinic Type" is chosen** Clinic Types are fixed and are the same throughout England Enter only one Clinic type. However you may enter more than one "Clinical Term" **Complete a Clinical Term** a. If a clinical term (such as "Entropion") is entered in the search field in CaB then this will show all the services which see patients with this problem or diagnosis. b. This is particularly useful for conditions that the GP may not recognise, such as "Keratoconus" or "Macular Dystrophy
Russells Hall Hospital (RHH) Eye Department, Pensnett Road, Dudley, DY1 2HQ Contact the eye casualty triage in the Emergency Referral Clinic; Tel 01384 456111 ask for Ophthalmic Triage Bleep or X 3633		
Birmingham & Midland **Eye Centre (BMEC)** City Hospital, Dudley Road, Birmingham B18 7QH Contact the eye casualty triage nurse on: 0121 507 6780 Fax No 0121 507 6773/6711	The URC will Triage and contact the patient in due course (usually that day) to arrange an appointment in a timescale recommended by the consultant based on the information provided on the form. Optometrists must not cause undue concerns for patients by indicating a timescale for their appointment as this will be decided by the consultant based on the information on the referral.	
Wolverhampton Eye Emergency Referral Unit New Cross Hospital, Wolverhampton Road, Wolverhampton, WV10 0QP Contact the eye casualty triage - 01902 695805 Fax 01902 695842 Email to rwh-tr.optometry-referrals@nhs.net	The ERS entry may be completed by a non-medical GP staff member, so the Optometrist should ensure any writing on the form is clearly legible. Outcomes from the Referral will be sent to the GP and the patient, so if the Optometrist requires feedback it is recommend they ask the patient to share their letter with you.	

This list is not exhaustive & practitioners should always apply their clinical judgement when deciding on the appropriate clinical pathway for a patient.