UHL Ophthalmology Triage Tool (2025)

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