NHS
Oxfordshire
Clinical Commissioning Group

Referral Guideline
Ophthalmology Overview

Scope:	All Ophthalmology referrals	**Clinical Lead (CCG):**	Shelley Hayles
Authors:	Chetan Patel, Stella Hornby, Paul Rosen, Nita Mahalingham, Shelley Hayles, Tom Stocker	**Clinical Lead (OUH):** **Date:**	CK Patel 26/2/18
Service contact details for booking issues:	Tel: 01865 234567 Email for appointment enquiries: Eye.Hospital@ouh.nhs.uk Eye emergencies: 01865 234567 Horton General Hospital eye clinic: 01295 229682		

For all MECS referrals, check the patient does not have red flags first and is suitable for the service.
A guideline can be found at occg.info/MECStriage

For all suspected cancer referrals: Send all 2ww referrals through OEH.UrgentReferrals@nhs.net, or oxon.eyes@nhs.net if you are unsure. Notify the patient and their GP that a referral has been made and that the patient is to make themselves available for a hospital appointment in the next two weeks.

If you are making referrals for any other conditions not included in this guide, please email occg.plannedcare@nhs.net so that we can improve this resource.

An up to date version of this guidance is available at occg.info/Optomreferrals

Condition / presentation	Referral to	
Anterior Chamber and Iris		
Hypopyon/ Hyphaema	Eye Casualty	
Iritis / Uveitis	Undiagnosed or not on treatment – Eye Casualty	
Rubeosis	If IOP raised	Eye Casualty
	If normal IOP	Urgent referral to vascular medical retina clinic
Suspected Iris Melanoma	Iris Naevi	Routine referral to external eye disease clinic
	Lump	2 week wait referral to external eye disease clinic
Cornea NB red flag symptoms		

Condition / presentation	Referral to		
Corneal Dystropies inc. Keratoconus	If no red flag symptoms		Routine referral to cornea clinic
	If red flag symptoms		Eye Casualty
Superficial keratitis	MECS		
Keratitis	Eye Casualty		
Persistent Recurrent Erosion	If no red flag symptoms		Treat with daily administration of lacrilube or VisuXL each evening before bed. If symptoms persist beyond 3 months, refer to either a peripheral clinic (e.g. Wantage), cornea or general clinics.
	If red flag symptoms		Eye Casualty
Suspected Microbial Keratitis in CL wear	Eye Casualty		
Diabetic Eye Disease			
New Vessels at Disc, Subhyaloid Haem, RD	Eye Casualty		
Exudates <1DD from Fovea	Refer via GP with a photo and note to check when last screened or seen in the Eye Hospital. Note to suggest that GP refer to vascular medical retina clinic if patient not already known to the hospital services, or use oxon.eyes@nhs.net with attached photo if the patient requires an Urgent appointment.		
Pre prolif / moderate non-prolif DR	Routine		Referral to medical retinal clinic
	If you suspect a 1 month or Urgent referral is required		Use oxon.eyes@nhs.net first to query
Vitreous Haemorrhage or Rubeosis	Eye Casualty (include IOPs)		
External Eye NB red flag symptoms			
Adenovirus	Sore, photophobic or blurred vision.	Yes	Eye Casualty
		No	No referral required
Episcleritis	MECS		
Papillary Conjunctivitis	MECS		
Persistent uncomfortable Conjunctival Cysts	MECS		
Persistent Hayfever Conjunctivitis in Juveniles	MECS		

Condition / presentation	Referral to		
Pterygium	MECS		
Scleritis	Eye Casualty		
Severe Dry Eye	MECS		
Suspicious Melanosis	Routine to external eye disease clinic		
Vernal Conjunctivitis	Corneal involvement	No	MECS
		Yes	Eye Casualty
Eye Movement			
Juvenile Squint / Amblyopia	1 month referral to community Orthoptist		
Incommitancy	1 month referral to Orthoptics and Occular Motility clinic		
New Acquired Squint-acute	Eye Casualty (3rd nerve)		
Fundus			
Central Serous Retinopathy	Photographs and OCT mac available	Send to oxon.eyes@nhs.net	Tell patient to avoid steroids in all forms where possible (including sprays, creams & inhalers)
	Photos or OCT mac not availabile	Refer to Macula Clinic	
	Choroidal neovascularisation suspected	Eye Casualty	
Choriodoretinitis	Active		Eye Casualty
	Old		Do not refer, counsel in practice
Commotio Retinae from Recent Trauma	Eye Casualty		
Congenital disc defects + Colobomas in Children	Infants	Concerned about Nystagmus	Squint Urgent referral to Paediatric Ophthalmology
		No Nystagmus	Squint Routine referral to Paediatric Ophthalmology
	Children		Routine referral to Paediatric Ophthalmology.
	Adults		Routine referral if not previously assessed
Central Retinal Artery Occlusion	Eye Casualty. Treat as Urgent if within the last 6 hours.		

Condition / presentation	Referral to		
Retinal Vein Occlusion (both Central and Branch)	Ask practice to check blood pressure, and bloods i.e. FBC, ESR, glucose, and lipids prior to referral	no macular oedema	Suggest routine referral to vascular MR clinic
		macular oedema	Suggest urgent referral within 1 month to vascular medical retinal clinic
Disc Haemorrhage	No signs of glaucoma and known risk factors e.g. hypertension or diabetes		No referral required. Patient to make contact with their GP (routine, not urgent) to discuss whether additional cardiovascular screening is required (e.g. bloods, BP)
	Possible glaucoma, or symptoms		Refer Routinely to general or glaucoma clinic with IOP and visual fields
Disc Pallor	Routine referral with visual fields to Neuro-Ophthalmology clinic		
Hollenhorst plaques	Refer to GP explaining that this is end organ arterial disease and recommending cardiovascular secondary prevention		
Hypertensive Retinopathy	grade 4 changes (i.e. swollen discs, macular oedema, exudates)		Routine referral to medical retinal clinic
	New finding and grade 3 or less		Patient to book a routine GP appointment
	Not new finding and grade 3 or less		No further action required
Macular Degeneration	Wet		Hospital AMD rapid access service wetamd.oxon@nhs.net
	Dry or longstanding		No referral except to confirm diagnosis, for registration, or for LVA's. Where considering a referral, please use email advice first oxon.eyes@nhs.net
Macular Hole	1 month referral to vitreoretinal clinic		
Macula Oedema	Acute or recent (within 1 month)		Eye casualty
	Over 1 month and not acute		Refer to vitreoretinal clinic
Papillaoedema	If symptoms of raised intracranial pressure ie headache, nausea, vomiting, sixth nerve palsy EED or if out of hours discuss with on call ophthalmologist. If no intracranial pressure symptoms but definite swollen discs, Eye Casualty avoiding weekends. If uncertain disc swelling and patient asymptomatic, send a photo and if possible visual fields to oxon.eyes@nhs.net. If photograph not possible, Urgent referral to Neurophthalmic Clinic.		

Condition / presentation	Referral to		
Macular Pucker (epiretinal membrane)	Routine referral to vitreoretinal clinic		
Retinal Haemorrhages	If visual symptoms, send a photograph and description to oxon.eyes@nhs.net if not possible, send to Eye Casualty. If no visual symptoms, send to GP to check BP, FBC, ESR, glucose and lipids.		
Retinal tears and detachments	Eye Casualty If fully operculated flat tears with no symptoms, Routine referral to vitreo retinal clinic with retinal detachment warning to patient and instruction to attend Eye Casualty if they get symptoms		
Retinitis Pigmentosa and other dystrophies	Routine referral with IOP and visual fields if possible to genetic/medical retina clinic Prof Downes If a child - refer to Paediatric Ophthalmology		
Retinoschisis	Routine referral to vitreo retinal clinic		
Recent Retrobulbar/ Optic Neuritis/ Papilitis	Eye Casualty. Include visual fields if possible.		
Suspected Melanoma	Urgent referral to Prof Downes via OEH.UrgentReferrals@nhs.net with photos if available.		
Suspected Temporal Arteritis	No eye symptoms		Call GP duty doctor same day to hand over patient for urgent Rheumatological investigations
	Eye symptoms		Eye Casualty
Unidentified Fundus Lesion	Send a retinal photograph to the email advice line oxon.eyes@nhs.net		
Glaucoma			
Acute Narrow Angle Glaucoma	Acute		Eye Casualty
	Suspect subacute intermittent		Urgent
IOP>31mmHg	Eye Casualty with volk, slit lamp bio and pictures if possible.		
Glaucoma suspect / raised pressures	IOP under 24mmHg	Don't refer, no further action required	See https://www.oxfordshireloc.org.uk/public/optometry-services/glaucoma/ for how patients can access the service. Please refer to the NICE guidelines
	IOP between 24mmHg and 31mmHg	Refer through Glaucoma Referral Refinement Scheme. Include Volk, slit lamp bio and 2D pictures in the referral to GRRS.	
	IOP over 31mmHg	Eye Casualty	

Condition / presentation	Referral to	
Lens		
Opacities disabling the patient	1 month referral to the cataract clinic	
Subluxated Lens	IOP normal	Routine referral to cataract clinic
	IOP raised	1 month referral to cataract clinic
Mild or Moderate Cataract	Best correct visual acuity in the affected eye is 6/12 or worse or the patient is very symptomatic.	Routine referral to the cataract clinic. Request accelerated access if there are work or driving problems. Encourage patient to consider whether they require surgery using shared decision form and offer other visual aids where possible prior to referral. http://www.oxfordshireccg.nhs.uk/professional-resources/documents/clinical-guidelines/ophthalmology/cataracts.pdf
	Best corrected visual acuity in the affected eye is 6/9 or better, and the patient's symptoms are not having a significant impact on their wellbeing.	No referral required. Seek to support patient with further visual aids where possible. Oxfordshire's policy can be found here http://www.oxfordshireccg.nhs.uk/policies-and-procedures/126b-cataract-removal-in-adults/30318
Lids NB red flag symptoms		
Basil Cell Carcinoma	Urgent referral to the Oculoplastic clinic (Mr Norris)	
Dacryocystitis	Typical presentation (no red flags)	1 month referral to Occuloplastics clinic with recommendation to GP to commence antibiotic (consider augmentin as first line)
	Red flags present	Eye Casualty
Ectropion	If the patient requires examination, refer them to MECS Surgery for Ectropion is not routinely funded for cosmetic reasons http://www.oxfordshireccg.nhs.uk/professional-resources/documents/commissioning-statements/280-ectropion-and-entropion.pdf	

Condition / presentation	Referral to	
Entropion	If any of the following are persistent: - Ocular irritation - Recurrent bacterial conjunctivitis - Reflex tear hypersecretion - Superficial keratopathy - Risk of ulceration and microbial keratitis (inflammation of the cornea)	Urgent referral to Occuloplastics clinic
	Above symptoms are not present, or where present are not persistent.	Support use of appropriate over the counter medicines as necessary. Surgery for Ectropion and Entropion for cosmetic reasons is not normally funded, see http://www.oxfordshireccg.nhs.uk/professional-resources/documents/commissioning-statements/280-ectropion-and-entropion.pdf
	Red flags present	Eye Casualty
Trichiasis	First presentation	MECS
	Patient has already tried MECS and is seeking further care	Routine referral to the occuloplastics clinic
Exophthalmos	Acute and visual loss	Eye Casualty
	Acute and unilateral and no visual loss	Urgent Oculoplastics
	Chronic bilateral	Routine Oculoplastics and ask GP to check thyroid function beforehand
Lacrimal Duct Obstruction	Patient is not fit for a general anaesthetic or would prefer to live with the symptoms than have a major eye operation	No further action required
	Patient is fit for surgery and would prefer a major eye operation	Routine oculoplastics clinic
Orbtial Cellulitis	Eye Casualty	
Persistent Blepharitis	MECS	
Persistent Stye/ Chalazion	MECS	

Condition / presentation	Referral to	
Ptosis - acquired senile	Patient has the following symptoms and wants to pursue major eye operation: • down-gaze ptosis impairing reading and other close-work activities AND • a chin-up backward head tilt due to visual axis obscuration OR any one of the following: • margin reflex distance 1 (MRD(1)) of 2mm or less • eyelid skin fold to reflex distance of 2mm or less • superior visual field loss of at least 12 degrees or 24% • central visual interference due to upper eyelid position	Routine referral to Occuloplastics clinic
	Patient does not meet the above thresholds	No further action required. Individual funding requests are available if the patient would like to pursue treatment due to exceptional circumstances
	3rd nerve palsy	Eye Casualty
Pulsating Proptosis	Eye Casualty	
Suspected Eyelid Neoplasm	2 week wait occuloplastic referral	
3rd Nerve Palsy	Eye Casualty	
Thyroid Eye Disease	Corneal exposure or optic nerve compression	Eye Casualty
	Diploplia	Routine referral to Orthoptics
	Other	Routine referral to Mr Norris joint thyroid clinic
Neurophthalmology		
Specific Visual Field Defect	If homonymous visual field defect without any previous stroke or neurological condition	1 month referral to neuro-ophthalmology clinic
	Acute and symptomatic	Eye Casualty

Condition / presentation	Referral to	
TIA / Amaurosis Fugax	Call duty doctor at GP practice to refer patient to TIA pathway If GP not available or unsure of diagnosis, send to Eye Casualty	
Pupillary Defects (not including Horners - Adie)	Routine referral to neuro-ophthalmology clinic	
Hornes - Adie	Leave / advice only Can consider referral to GP if new	
Trauma NB red flag symptoms		
Chemical Injury	Eye Casualty	
Penetrating Injury (including foreign bodies with metal, rust, plaster or corneal involvement)	Eye Casualty	
Foreign Body	MECS	
Lacerations	Eye Casualty	
Vitreous NB red flag symptoms		
Floaters (PVD)	MECS	
Floaters and Flashes of recent onset	MECS	
Suspected retinal break +/- operculum	Eye Casualty	
Vitreous Haemorrhage	Eye Casualty	
Vitritis	No red flags	Routine referral ocular inflammation clinic
	Red flags	Eye Casualty

Signatures	
CCG Clinical Lead:	
CCG Manager:	
Provider clinical lead:	
LOC chair:	
Planned review date: 01/04/2021. Please email occg.plannedcare@nhs.net if you notice this is out of date.	