REFERRAL GUIDELINES FOR OCULAR PATHOLOGY

This list is not exhaustive & practitioners should always apply their clinical judgement and be mindful of CoO Guidelines when deciding on the appropriate clinical pathway for a patient.

	Routine Routine or appropriate direct referral pathway	**Urgent** Within one week	**Emergency** Within 24 hours
		Conditions	
Anterior	• Symptomatic entropion/ectropion • Chronic Exophthalmos/proptosis • Persistent lid disease/cyst/hordeolum • Longstanding ptosis • Severe dry eye • Pterygium (affecting visual axis) • Persistent epiphora • Keratoconus • Recurrent corneal erosion syndrome • Corneal dystrophy (reduced VA) • Allergic conjunctivitis • Naso-lacrimal duct obstruction • Cataract • IOP >=24mmHg <32mmHG **Follow Local Glaucoma Pathway**	• Iris rubeosis • Repeatable IOP >32 <40mmHgmmHg • Severe keratitis • Acute dacryoadenitis • Acute dacryocystitis if mild • Unilateral blepharitis if carcinoma suspected • Chlamydial conjunctivitis (refer to GP) • CMV and candida retinitis • Commotio retinae • Corneal hydrops if vascularisation present • Keratoconjunctivitis especially with severe corneal involvement or ocular cicatricial pemphigoid are suspected • Steroid induced glaucoma	**Red eye (non-traumatic)** • Acute Angle Closure Glaucoma • Painful recent post-op/hypopyon/blebitis • Corneal graft rejection • Scleritis • Infective keratitis • Herpetic infection: simplex & zoster • Iritis/Uveitis • Severe corneal abrasion • Acute dacryocystitis **Red eye (traumatic)** • Chemical burns – irrigate & refer asap • Penetrating injuries • Hyphaema • Embedded foreign body
Visual loss	• Gradual loss of VA >4weeks with no sudden loss	• Amaurosis fugax: refer via GP same day for TIA work-up • Retrobulbar/Optic neuritis	• Possible Temporal Arteritis with visual symptoms • Sudden visual loss unknown cause (<24hours)
Posterior	• Retinal haemorrhages • Branch retinal vein occlusion } **refer within 4wks;** • Central Serious Retinopathy } **if not electronic you must check the referral is processed** • Suspect glaucoma/abnormal discs • Dry AMD requiring registration/LVA • Retinitis Pigmentosa • Macular hole • Epiretinal membrane (symptomatic and VA worse than 6/9) • Diabetic maculopathy **(If not under care of HES & VA worse than 6/9 HES should see px in 13/52)**	• Vitritis • Vitreous haemorrhage (non-PVD) • Nystagmus with other neurological signs • Wet AMD } **REFER ACCORDING TO** • CRVO } **THE PATHWAY FOR THE** • Myopic CNV } **PATIENT'S AREA** • Retrobulbar/Optic neuritis • Diabetic proliferative retinopathy **(if not already under HES, px should be seen in 6/52 in HES)**	• Retinal artery occlusion <24hours • IOP > 40mmHg • Retinal detachment • Floaters/photopsia <48 hours + tobacco dust • Retinal tears and breaks • Papilloedema • PVD related vitreous haemorrhage • New Pre Retinal Haemorhhage • Endophthalmitis
Other	• Repeatable suspicious field defects • Long standing squint requiring correction • Children's manifest squint, amblyopia/reduced VA **REFER VIA DIRECT ORTHOPTIC PATHWAY**	• Suspected cancers • Suspected compressive lesion • New pupillary defects	• Pre Septal/Orbital cellulitis • Acute proptosis • Acute onset diplopia/squint/ptosis/nerve palsy • New facial palsy