NSW Health

Ophthalmology State-wide Referral Criteria for Public Outpatient Services

This document is to be used as a guide for referrers and clinicians in NSW public outpatient services

The aim of SRC is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services.

This document contains Ophthalmology SRC for the following presenting conditions:

- Cataracts (adult)
- Age-related macular degeneration (adult)
- Diabetic retinopathy (adult)
- Glaucoma (adult)
- Cataracts (paediatric)
- Strabismus or ocular motility disorder (paediatric)
- Ptosis (paediatric)
- Reduced visual acuity (paediatric)
- Anisocoria (unequal pupil size) (paediatric)
- Optic nerve head swelling (paediatric)

Notes

- Ophthalmology SRC are applicable to NSW Local Health Districts and Specialty Health Networks with existing public ophthalmology and applicable allied health-led, nurse-led or medical/surgical-led outpatient services that manage the identified presenting conditions
- Ophthalmology SRC are applicable where the identified presenting conditions managed by ophthalmologists are delivered in private practice as part of public-private hospital arrangements
- Ophthalmology SRC does not intend to change eligibility in terms of presenting conditions managed and referral sources accepted for NSW public ophthalmology and applicable allied health-led, nurse-led or medical/surgical-led outpatient services, however some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local context
- Ophthalmology SRC supports patients to be managed by the most appropriate member(s) of the multidisciplinary care team in the most appropriate setting based on their presenting condition
- Ophthalmology SRC sets thresholds for referral to NSW public ophthalmology and applicable allied health-led, nurse-led or medical/surgical-led outpatient services and expected clinical urgency category based on clinical need

Acknowledgements

NSW Health would like to extend its appreciation to all clinicians, administrators and consumers who contributed to the development of Ophthalmology SRC for NSW public outpatient services. NSW Health would also like to acknowledge the SRC developed by QLD Health, VIC Health, SA Health and WA Health which has been referenced to support the development of Ophthalmology SRC for NSW public outpatient services.

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Glossary

The structure for SRC in NSW is divided into the following five criterion.

In some cases, component(s) may not be applicable to each presenting condition. This will be denoted by 'Nil'.

Criterion	Description
Emergency	• Clinical presentations or 'red flags' where referring health professionals should consider redirecting the patient to an Emergency Department or urgent care service, or seeking medical advice (e.g. phone on-call medical practitioner) • These criteria should not be used by referring health professionals to refer to an NSW public specialist outpatient service
Out of scope / not routinely provided	• Symptoms, conditions and/or presentations that would not routinely be provided by NSW public specialist outpatient services (i.e. could be optimally and safely managed in primary care) • These criteria acknowledge and permit exceptions, where clinically appropriate
Access / prioritisation	• Symptoms, conditions and/or presentations that advise referring health professionals, clinicians, patients and carers suitability for management by NSW public specialist outpatient services • These criteria are classified by expected clinical urgency category and clinically recommended timeframes to be seen for a new outpatient appointment (i.e. Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days) • These criteria are only applicable where NSW public specialist outpatient services exist and manage the identified presenting condition
Referral requirements	• Mandatory information that is to be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category
Other content	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

Ophthalmic emergencies

Note: this emergency criteria are not an exhaustive list of ophthalmic emergencies. Please refer to HealthPathways for more information.

Presenting Condition	Emergency Criteria
Absent or poor red reflex (paediatric and adult)	• If absent or poor red reflex, contact on-call hospital consultant or registrar same day for advice • White pupil in one or both eyes (paediatric only)
Acute neuro-ophthalmic signs or symptoms (paediatric and adult)	• Acute onset anisocoria (unequal pupil size) with or without neurological signs • Sudden onset strabismus (ocular misalignment) • Acute ptosis • Acute onset nystagmus
Acute red eye (paediatric and adult)	• Abnormal cornea, indicating Herpes simplex infection, bacterial or acanthamoebal ulcer, marginal keratitis, or foreign body or corneal abrasion • Photophobia and marked decrease in visual acuity • Conjunctivitis with reduced vision or not responding to treatment • Red eye in the context of corneal transplant or contact lens wear • Acute angle closure crisis • Acute painful eye with sudden loss of vision • Scleritis • Acute anterior uveitis (iritis) • Hypopyon • Hyphaema • Flash burn
Acute visual disturbance (paediatric and adult)	• Sudden, persistent loss of vision • Painless loss of vision over hours to days • Reduced visual acuity, colour vision, brightness and contrast vision • Swollen optic disc • Acute onset monocular visual loss • Transient visual loss • Orbital pain, with or without eye movement • Recent history of increased number of visual floaters and/or flashes • Dark shadow in the vision of the affected eye • Fundus examination shows large areas of haemorrhage and/or emboli
Blow-out fracture (paediatric and adult)	• Pain on eye movements • Nausea or vomiting on eye movements

	• Minimal redness and swelling (white-eye blow-out fracture in a child) • Local tenderness • Diplopia • Eyelid swelling • Crepitus after nose blowing • Findings suggestive of minimal periorbital haemorrhage, sunken (enophthalmic) globe and restricted eye movement in an unwell child • Nose bleed • Ptosis • Localised tenderness • Suspected or documented orbital floor fractures • Evidence of ocular injury
Chemical burns (paediatric and adult)	• Acid or alkali in contact with eye
Corneal foreign body (paediatric and adult)	• Any foreign body penetration of the cornea or retained foreign body • Foreign body is not completely removed • Underlying surface defect is opaque and indicative of an abscess • Persistent epithelial defect (i.e. significant or minimal improvement within 48 hours)
Lid lacerations and infections (paediatric and adult)	• Eyelid laceration is associated with ocular trauma requiring surgery (e.g. ruptured globe, intraorbital foreign body) • Laceration position is nasal to either the upper or lower eyelid punctum • Extensive tissue loss or distortion of the anatomy • Full thickness laceration • Laceration involves the lid margin • Suspected pre-septal or orbital cellulitis
Ocular and orbital trauma (paediatric and adult)	• All penetrating trauma • Reduced ocular movements • Findings are suggestive of intraocular haemorrhage, ruptured globe or orbital wall fracture
Optic nerve head swelling (paediatric and adult)	• Optic nerve head swelling with neurological signs or symptoms, vision change and/or headache • Optic nerve head swelling with retinal haemorrhages or exudates
Ptosis (paediatric and adult)	• Sudden onset ptosis with or without diplopia • Ptosis with other neurological signs • Ptosis with anisocoria (unequal pupil size)

Age-related macular degeneration (adult)	• Sudden loss of vision • New onset of reduced central vision and/or distortion due to wet age-related macular degeneration (AMD) • New fluid on a macular optical coherence tomography (OCT) scan consistent with wet AMD
Cataracts (adult)	• Recent cataract surgery with increasing pain, redness, blurring or flashes/floaters • Acute angle closure
Diabetic retinopathy (adult)	• Sudden loss of vision • Proliferative Diabetic Retinopathy (PDR) • Vitreous haemorrhage • Severe non-proliferative diabetic retinopathy (NPDR) in pregnancy • Centre-involving macular oedema in pregnancy • Retinal detachment
Glaucoma (adult)	• Acute angle closure crisis • Acute painful eye with sudden loss of vision • Intraocular pressure (IOP) > 35 mmHg • Red and painful eye with history of glaucoma drainage surgery
Anisocoria (unequal pupil size) (paediatric)	• Acute onset anisocoria (unequal pupil size) with or without neurological signs
Cataracts (paediatric)	• New cataract for aged < 3 years • Cataract with red eye • Cataract with nystagmus • Cataract with congenital glaucoma
Congenital glaucoma (paediatric)	• Big eye(s) (horizontal corneal diameter > 12mm) • Cloudy cornea • Photosensitivity with tearing
Reduced visual acuity (paediatric)	• Sudden and/or severe vision loss in a child
Strabismus or ocular motility disorder (paediatric)	• Sudden onset strabismus (squint) with diplopia • Suspicion of nerve palsy with other cranial nerve and/or neurological signs • Abnormal red reflex or lack of visual response

Out of scope / Not routinely provided

Presenting Condition	Out of scope / Not routinely provided
Low vision assistance (paediatric and adult)	• Low vision assistance *(see Vision Australia, Guide Dogs Australia and Macular Disease Foundation Australia for more information)*
Age-related macular degeneration (adult)	• Family history but asymptomatic • Retinal Pigment Epithelial (RPE) changes (previously called Dry Age-related Macular Degeneration) • Drusen • Patients able to continue anti-vascular endothelial growth factor (VEGF) treatment in the community
Cataracts (adult)	• Lens opacities that do not cause visual symptoms or limit daily activities • Without an optometrist, orthoptist or ophthalmologist report • Patient does not want surgery • Assessment with optometrist and not affecting activities of daily living (ADLs) • Refractive lens exchange (except for medical reasons)
Diabetic retinopathy (adult)	• Routine referral for screening Note: refer to local eye health professional for fundus photography • Mild non-proliferative diabetic retinopathy (NPDR) without macular oedema *(these patients should have an optical coherence tomography (OCT) or fundus photography by their local eye health professional. Refer to RANZCO Guidelines for timeframes.)* Note: pregnant patients with any diabetic retinopathy should be referred
Glaucoma (adult)	• Ocular hypertension with intraocular pressure (IOP) < 28 mmHg with normal discs/fields and no other signs or risk factors for glaucoma • Screening due to presence of glaucoma in family history
Cataracts (paediatric)	• Screening for cataract for aged ≥ 8 years that do not have current treatment regime, medication or systemic disease that may cause development of cataract • Screening for cataract aged ≥ 8 years due to family history of congenital cataract

Presenting Conditions

Cataracts (adult)

Emergency
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.
• Recent cataract surgery with increasing pain, redness, blurring or flashes/floaters • Acute angle closure
Out of scope / not routinely provided
• Lens opacities that do not cause visual symptoms or limit daily activities • Without an optometrist, orthoptist or ophthalmologist report • Patient does not want surgery • Assessment with optometrist and not affecting activities of daily living (ADLs) • Refractive lens exchange (except for medical reasons)
Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Cataract with significant impact on activities of daily living (ADLs) and best corrected visual acuity (BCVA) 6/60 or worse in both eyes
Category 2 (clinically recommended to be seen within 90 calendar days)	• BCVA worse than 6/60 in one eye • Cataract causing other ocular complications interfering with management of other sight-threatening problems • Cataract in only functional eye
Category 3 (clinically recommended to be seen within 365 calendar days)	• Cataract with significant impact on ADLs after a thorough visual assessment and non-surgical management (including glasses) by an eye health professional, and patient open to having surgery

Referral requirements
• Best corrected visual acuity (BCVA) (in each eye) by eye health professional • Refraction • Whether first or second eye • Symptoms and duration of problem • Functional impact on activities of daily living (ADLs) • Other relevant ocular pathology • Interpreter required (if so, preferred language)
Other content
• Patient health summary (including relevant medical history and current medications) • Guardianship status • Professional driver with specific visual acuity requirements for employment • Driving status

- Social circumstances
- Catquest-9SF assessment tool
- Cat-PROMS assessment tool
- If the patient is a falls risk
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Age-related macular degeneration (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- Sudden loss of vision
- New onset of reduced central vision and/or distortion due to wet age-related macular degeneration (AMD)
- New fluid on a macular optical coherence tomography (OCT) scan consistent with wet AMD

Out of scope / not routinely provided

- Family history but asymptomatic
- Retinal pigment epithelial changes (previously called dry age-related macular degeneration)
- Drusen
- Patients able to continue anti-vascular endothelial growth factor (VEGF) treatment in the community

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil *Note: A new diagnosis of wet age-related macular degeneration (AMD) should be seen as an 'Emergency'*
Category 2 (clinically recommended to be seen within 90 calendar days)	• Patients who are unable to continue receiving anti-vascular endothelial growth factor (VEGF) treatment in the community
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Referral requirements

- Optometrist, orthoptist or ophthalmologist report, including visual acuity, refraction and retinal examination
- Best corrected visual acuity (BCVA) by eye health professional
- Retinal imaging or optical coherence tomography (OCT) results
- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Professional driver with specific visual acuity requirements for employment
- Driving status
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population

Diabetic retinopathy (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- Sudden loss of vision
- Proliferative diabetic retinopathy (PDR)
- Vitreous haemorrhage
- Severe non-proliferative diabetic retinopathy (NPDR) in pregnancy
- Centre-involving macular oedema in pregnancy
- Retinal detachment

Out of scope / not routinely provided

- Routine referral for screening
  Note: refer to local eye health professional for fundus photography
- Mild non-proliferative diabetic retinopathy (NPDR) without macular oedema
  (these patients should have an optical coherence tomography (OCT) or fundus photography by their local eye health professional. Refer to RANZCO Guidelines for timeframes.)
  Note: pregnant patients with any diabetic retinopathy should be referred

Access / prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Diagnosis of diabetes and any of the following are present:
	  ○ Severe non-proliferative diabetic retinopathy (NPDR)
	  ○ Centre-involving macular oedema
	  ○ Non-centre involving macular oedema in pregnancy
	
	Note: Definition of centre-involving diabetic macular oedema: thickening within 500 microns of the foveal centre associated with microaneurysms, haemorrhages or hard exudates)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Moderate non-proliferative diabetic retinopathy (NPDR) • Mild NPDR seen at 1st trimester screening in pregnancy (should be reviewed by ophthalmologist between 16 to 20 weeks gestation) • Non-centre involving macular oedema
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Referral requirements

- Retinal assessment including best corrected visual acuity (BCVA), digital fundus photography and refraction with optometrist, orthoptist or ophthalmologist
- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Optical coherence tomography (OCT) results

- Type of diabetes and duration of disease
- Previous eye treatment (e.g. retinal laser)
- HbA1c (most recent within the last 6 months and previous 3 results, if available)
- Blood pressure
- Lipid profile
- Recent eGFR
- Professional driver with specific visual acuity requirements for employment
- Driving status
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Glaucoma (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- Acute angle closure crisis
- Acute painful eye with sudden loss of vision
- Intraocular pressure (IOP) > 35 mmHg
- Red and painful eye with history of glaucoma drainage surgery

Out of scope / not routinely provided

- Ocular hypertension with intraocular pressure (IOP) < 28 mmHg with normal discs and fields and no other signs or risk factors for glaucoma
- Screening due to presence of glaucoma in family history

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Uncontrolled intraocular pressure (IOP) > 26 mmHg and severe disc damage and/or field loss • IOP 30 to 35 mmHg

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Initial IOP treatment by an optometrist and without ophthalmology review
	• Likely diagnosis of glaucoma and any of the following are present:
	  ○ Signs of early disc damage or field loss consistent with glaucoma
	  ○ IOP 28 to 30 mmHg without disc damage or field loss
	  ○ Suspicion of narrow iridocorneal angles with risk of angle closure glaucoma

Category 3
(clinically recommended to be seen within 365 calendar days)
	• Controlled IOP but unable to continue receiving care under private ophthalmologist
	• Narrow angles with controlled IOP
	• IOP 22 to 27 mmHg with any of the following are present:
	  ○ Central corneal thickness < 520 microns
	  ○ High risk medicine (e.g. steroids)
	  ○ History of trauma
	  ○ Pseudoexfoliation
	  ○ Pigment dispersion
	  ○ High myopia
	  ○ Family history of glaucoma

Referral requirements

- Optometrist, orthoptist or ophthalmologist report including best corrected visual acuity (BCVA), refraction, intraocular pressure (IOP), visual field tests and disc assessment
- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Private ophthalmologist report (if transferring care)
- Optical coherence tomography (OCT) results
- Gonioscopy
- Pachymetry
- Optic disc photos
- Family history of glaucoma
- Professional driver with specific visual acuity requirements for employment
- Driving status
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Cataracts (paediatric)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- New cataract for aged < 3 years
- Cataract with red eye
- Cataract with nystagmus
- Cataract with congenital glaucoma

Out of scope / not routinely provided

- Screening for cataract aged ≥ 8 years that do not have current treatment regime, medication or systemic disease that may cause development of cataract
- Screening for cataract aged ≥ 8 years due to family history of congenital cataract

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Aged between 3 to 8 years with concerns of poor vision due to cataract • Aged ≥ 8 years with developmental delay or other issues that does not allow referrer to assess visual acuity • Patient requires cataract surgery referred by private ophthalmologist
Category 2 (clinically recommended to be seen within 90 calendar days)	• Aged ≥ 8 years with newly recognised cataract • Aged ≥ 3 years with documented or suspected cataract and vision 6/12 or worse in affected eye • Aged < 8 years and screening for cataract due to current treatment regime, medication or systemic disease that may cause development of cataract • Aged < 8 years with family history of congenital cataract
Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≥ 8 years with previous congenital cataract surgery (without glaucoma)

Referral requirements

- Visual acuity (in each eye) from an eye health professional (optometrist, orthoptist or ophthalmologist) (patient aged ≥ 8 years only)
- Refraction (patient aged ≥ 8 years only)
- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Medical history
- Medications
- Family history of congenital cataract
- Birth and pregnancy history
- If the patient identifies as Aboriginal and/or Torres Strait Islander

- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Strabismus or ocular motility disorder (paediatric)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- Sudden onset strabismus (squint) with diplopia
- Suspicion of nerve palsy with other cranial nerve and/or neurological signs
- Abnormal red reflex or lack of visual response

Out of scope / not routinely provided

- Nil

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Recent (up to 3 months in duration) or acute onset of strabismus (squint) • Aged < 1 year with constant strabismus

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Strabismus with systemic disease or developmental delay
	• Aged < 8 years with one or more of the following:
	  ○ Strabismus with visual asymmetry
	  ○ Reduced or loss of binocular vision
	  ○ Asymmetrical visual acuity

Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≥ 8 years with strabismus

Referral requirements

- Acute or longstanding onset (duration)
- Patient seen or not seen by another eye health professional (optometrist, orthoptist or ophthalmologist)
- Type of strabismus (constant or intermittent, unilateral or alternating)
- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Visual acuity or assessment of visual response
- Direction of ocular misalignment (vertical or horizontal, convergent or divergent)
- Corneal reflexes (e.g. Hirshberg test)
- Optometrist, orthoptist or ophthalmologist report performed within last 3 months
- Cover test
- Ocular motility
- Cycloplegic refraction
- Head posture
- Birth and pregnancy history
- Indicated for surgery
- If the patient identifies as Aboriginal and/or Torres Strait Islander

- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Ptosis (paediatric)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.

- Sudden onset ptosis with or without diplopia
- Ptosis with other neurological signs
- Ptosis with anisocoria (unequal pupil size)

Out of scope / not routinely provided

- Nil

Access / prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Aged < 8 years, and pupil is occluded and involving visual axis • Ptosis with pre-existing or known neurological disorder
Category 2 (clinically recommended to be seen within 90 calendar days)	• Aged < 8 years, and pupil is not occluded and not involving visual axis
Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≥ 8 years with ptosis

Referral requirements

- Interpreter required (if so, preferred language)

Other content

- Patient health summary (including relevant medical history and current medications)
- Optometrist, orthoptist or ophthalmologist report performed within last 3 months
- Visual acuity
- Refraction
- Impact of symptoms
- Photograph of head in primary position
- Birth and pregnancy history
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Reduced visual acuity (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.	
• Sudden and/or severe vision loss in a child	
Out of scope / not routinely provided	
• Nil	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Infant with visual failure to fix and follow • Visual response or behaviour not aligned with age expected response where best corrected visual acuity (BCVA) cannot be measured • BCVA worse than 6/24
Category 2 (clinically recommended to be seen within 90 calendar days)	• Aged < 8 years with BCVA worse than 6/18
Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≥ 8 years with BCVA worse than 6/18 • Aged < 8 years with BCVA worse than 6/12 • Unable to continue receiving care under private ophthalmologist • Referred from treating ophthalmologist for second opinion
Referral requirements	
• Orthoptist, optometrist or ophthalmologist report within last 3 months (only if aged ≥ 8 years only, excluding children with developmental delay) • Best corrected visual acuity (BCVA) (where possible) • Interpreter required (if so, preferred language)	
Other content	
• Patient health summary (including relevant medical history and current medications) • Assessment of visual field • Pupil reactions • Ability to fix and follow toy or light, or objection to occlusion with each eye separately • Ocular motility • Fundus exam • Difficulty with assessment (e.g. behavioural, psychological, neurodiverse) • Family history of visual problems • Cycloplegic or subjective refraction • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population	

Anisocoria (unequal pupil size) (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar.	
• Acute onset anisocoria (unequal pupil size) with or without neurological signs	
Out of scope / not routinely provided	
• Nil	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Aged < 1 year with anisocoria (unequal pupil size)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Longstanding anisocoria (unequal pupil size)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil
Referral requirements	
• Timeframe of onset • Interpreter required (if so, preferred language)	
Other content	
• Patient health summary (including relevant medical history and current medications) • Any associated changes to vision • Birth and pregnancy history • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population	

Optic nerve head swelling (paediatric)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant/registrar. • Optic nerve head swelling with neurological signs or symptoms, vision change and/or headache • Optic nerve head swelling with retinal haemorrhages or exudates	
Out of scope / not routinely provided	
• Nil	
Access / prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Optic nerve head swelling (if a new presentation) without other neurological signs or symptoms
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil
Referral requirements	
• Interpreter required (if so, preferred language)	
Other content	
• Patient health summary (including relevant medical history and current medications) • Visual acuity (if available) • If the patient identifies as Aboriginal and/or Torres Strait Islander • If the patient is considered 'at risk' and/or among a vulnerable, disadvantaged or priority population	