NSW Health

Adult 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 State-wide Referral Criteria (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 ophthalmic emergencies, ophthalmic presentations out of scope and the following presenting conditions:

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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Notes

- Ophthalmology SRC sets thresholds for referral, regardless of source, 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
- 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 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 may also be used by a range of specialists in private practice at their own discretion
- 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
- Some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local contextual factors and/or service availability
- Referring health professionals may consider local alternative care options, including private practice, Aboriginal Community Controlled Health Services and/or non-government organisations, where appropriate, for patients seeking to access specialist services

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 and 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
Required information	• 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
Additional information (if available)	• 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: Ophthalmic emergencies require immediate medical attention and/or intervention to prevent or manage serious harm to a patient. The list of emergency criteria below may not be exhaustive. Please refer to HealthPathways for more information.

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

Blow-out fracture (paediatric and adult)	• Crepitus after nose blowing • Diplopia • Evidence of ocular injury • Eyelid swelling • Findings suggestive of minimal periorbital haemorrhage, sunken (enophthalmic) globe and restricted eye movement in an unwell child • Localised tenderness • Minimal redness and swelling (white-eye blow-out fracture in a child) • Nausea or vomiting on eye movements • Nose bleed • Pain on eye movements • Ptosis • Suspected or documented orbital floor fractures
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 • Persistent epithelial defect (i.e. significant or minimal improvement within 48 hours) • Underlying surface defect is opaque and indicative of an abscess
Keratoconus (paediatric and adult)	• Keratoconus with acute graft rejection • Keratoconus with acute hydrops
Lid lacerations and infections (paediatric and adult)	• Extensive tissue loss or distortion of the anatomy • Eyelid laceration is associated with ocular trauma requiring surgery (e.g. ruptured globe, intraorbital foreign body) • Full thickness laceration • Laceration involves the lid margin • Laceration position is nasal to either the upper or lower eyelid punctum • Suspected pre-septal or orbital cellulitis
Ocular and orbital trauma (paediatric and adult)	• All penetrating trauma • Findings are suggestive of intraocular haemorrhage, ruptured globe or orbital wall fracture • Reduced ocular movements
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)	• Ptosis with anisocoria • Ptosis with other neurological signs • Sudden onset ptosis with or without diplopia Sudden onset ptosis with or without strabismus
Age-related macular degeneration (adult)	• New fluid on a macular optical coherence tomography (OCT) scan consistent with wet AMD • New onset of reduced central vision and/or distortion due to wet age-related macular degeneration (AMD) • Sudden loss of vision
Cataracts (adult)	• Acute angle closure • Recent cataract surgery with increasing pain, redness, blurring, flashes or floaters
Diabetic retinopathy (adult)	• Centre-involving macular oedema in pregnancy • Proliferative Diabetic Retinopathy (PDR) • Retinal detachment • Severe Non-Proliferative Diabetic Retinopathy (NPDR) in pregnancy • Sudden loss of vision • Vitreous haemorrhage
Eyelid malposition (entropion and ectropion) (adult)	• Entropion or ectropion with acute ocular pain and redness (i.e. at risk of microbial keratitis)
Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy (adult)	• Acute onset and debilitating painful eye with Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy
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
Lid lesions (adult)	• Periorbital skin cancer causing eyelid malposition with acute ocular pain and redness (i.e. at risk of microbial keratitis)
Macular hole or epiretinal membrane (adult)	• Nil emergency criteria
Posterior capsular opacity (adult)	• Nil emergency criteria
Pterygium (adult)	• Nil emergency criteria

Strabismus or ocular motility disorder (adult)	• Blow-out fracture • Sudden onset of limitation or reduction in ocular motility • Sudden onset binocular diplopia • Sudden onset strabismus

Ophthalmic presentations out of scope

Presenting condition	Out of scope (not routinely provided)
Keratoconus (paediatric and adult)	• Keratoconus with stable findings and tolerating visual aids (i.e. contact lenses, spectacles) with visual function meeting individual needs
Low vision assistance (paediatric and adult)	• Low vision assistance Note: see Vision Australia, Guide Dogs Australia and Macular Disease Foundation Australia for more information.
Age-related macular degeneration (adult)	• Drusen • Family history but asymptomatic • Patients able to continue anti-vascular endothelial growth factor (VEGF) treatment in the community • Retinal Pigment Epithelial (RPE) changes (previously called Dry Age-related Macular Degeneration)
Cataracts (adult)	• Assessment with optometrist and not affecting activities of daily living (ADLs) • Lens opacities that do not cause visual symptoms or limit daily activities • Patient does not want surgery • Refractive lens exchange (except for medical reasons)
Diabetic retinopathy (adult)	• Mild Non-Proliferative Diabetic Retinopathy (NPDR) • Moderate NPDR or non-centre involving diabetic macular oedema Note: these patients should have an optical coherence tomography (OCT) or fundus photography by their local eye health professional. Refer to RANZCO Guidelines for timeframes. • Routine referral for screening Note: refer to local eye health professional for fundus photography. *Note: pregnant patients with any diabetic retinopathy should be referred.*
Eyelid malposition (entropion and ectropion) (adult)	• Asymptomatic entropion or ectropion in the context of normal corneal sensation
Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy (adult)	• Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and Best Corrected Visual Acuity (BCVA) 6/12 or better without functional impact on activities of daily living

	• Patient does not want surgery
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
Lid lesions (adult)	• Benign eyelid lesions not affecting vision or causing functional deficit • Minor cosmetic eyelid lesions
Macular hole or epiretinal membrane (adult)	• Asymptomatic, visual acuity 6/9 or better and no significant distortion • Patient not willing to have surgery • Vitreo-macular traction not causing distortion or visual loss
Posterior capsular opacity (adult)	• Patient not willing to have YAG laser procedure
Pterygium (adult)	• Asymptomatic pterygium or symptoms treatable with topical therapy (i.e. not threatening visual axis) • Patient does not want surgery • Pterygium $\leq$ 1 mm from limbus to apex
Ptosis (adult)	• Patient does not want surgery
Strabismus or ocular motility disorder (adult)	• Nil out of scope criteria

Presenting conditions

Keratoconus (paediatric and 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 or registrar.	
• Keratoconus with acute graft rejection • Keratoconus with acute hydrops	
Out of scope (not routinely provided)	
• Keratoconus with stable findings, tolerating visual aids (i.e. contact lenses, spectacles) and visual function meeting individual needs	
Access and prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Newly diagnosed or suspected keratoconus and aged < 18 years

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Keratoconus with signs of progression (e.g. quantified change in keratometry or refraction over time)
	• Keratoconus at high risk of progression (e.g. aged 18-26 years, developmental delay, Down syndrome, atopy, persistent eye rubbing, sleep apnoea)
	• Suspected keratoconus and any of the following:
	  ○ Aged ≥ 18 years
	  ○ Family history of keratoconus in 1st degree relative

Category 3 (clinically recommended to be seen within 365 calendar days)	• Keratoconus with stable findings and not tolerating visual aids (i.e. contact lenses, spectacles)
Required information	
• Reason for referral • Details of the presenting condition including symptoms and their impact on activities of daily living • Provisional diagnosis • Information regarding atopy, sleep apnoea, history of connective tissue disease, family history of keratoconus, chromosomal abnormalities, and genetic conditions • Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA) and refraction • Evidence of corneal irregularity and corneal topography (as appropriate) • If the patient and/or carer requires an interpreter (if so, list preferred language)	

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Details of previous management (including type and duration)
- Previous ocular history
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Driving status
- Social circumstances
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

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 or registrar.

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

Out of scope (not routinely provided)

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

Access and 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

Required information

- Reason for referral
- Details of the presenting condition including symptoms and their impact on activities of daily living
- Provisional diagnosis
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA), refraction and retinal examination
- Retinal imaging or optical coherence tomography (OCT) results
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Professional driver with specific visual acuity requirements for employment
- Driving status
- If the patient is at increased risk of falling

- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

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 or registrar.

- Acute angle closure
- Recent cataract surgery with increasing pain, redness, blurring, flashes or floaters

Out of scope (not routinely provided)

- Assessment with optometrist and not affecting activities of daily living (ADLs)
- Lens opacities that do not cause visual symptoms or limit daily activities
- Patient does not want surgery
- Refractive lens exchange (except for medical reasons)

Access and 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

Required information

- Reason for referral
- Details of the presenting condition including symptoms, duration and functional impact on activities of daily living
- Provisional diagnosis
- Optometrist, orthoptist or ophthalmologist report
- Best Corrected Visual Acuity (BCVA) (in each eye) by eye health professional
- Refraction
- Whether first or second eye
- Other relevant ocular pathology
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- 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 at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

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 or registrar.

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

Out of scope (not routinely provided)

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

Note: pregnant patients with any diabetic retinopathy should be referred.

Access and 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

Required information

- Reason for referral
- Details of the presenting condition including symptoms and impact on activities of daily living
- Provisional diagnosis
- Retinal assessment including Best Corrected Visual Acuity (BCVA), digital fundus photography and refraction with optometrist, orthoptist or ophthalmologist

- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- 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)
- Blood pressure
- Lipid profile
- Recent eGFR
- Professional driver with specific visual acuity requirements for employment
- Driving status
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Eyelid malposition (entropion and ectropion) (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 or registrar.

- Entropion or ectropion with acute ocular pain and redness (i.e. at risk of microbial keratitis)

Out of scope (not routinely provided)

- Asymptomatic entropion or ectropion in the context of normal corneal sensation

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Entropion or ectropion with corneal epithelial damage
Category 2 (clinically recommended to be seen within 90 calendar days)	• Severe ectropion with tarsal conjunctival exposure • Symptomatic entropion
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic ectropion

Required information

- Reason for referral
- Details of the presenting condition including symptoms and impact on activities of daily living
- Provisional diagnosis
- Corneal assessment
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA)
- Presence or absence of tarsal conjunctival exposure
- Presence or absence of periorbital skin cancer
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Clinical image of lid position
- Presence of severe dry eye
- Previous ocular history
- Refraction
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Driving status
- Social circumstances
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy (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 or registrar.

- Acute onset and debilitating painful eye with Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy

Out of scope (not routinely provided)

- Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and Best Corrected Visual Acuity (BCVA) 6/12 or better without functional impact on activities of daily living
- Patient does not want surgery

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Painful eye with Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy not requiring emergency management
Category 2 (clinically recommended to be seen within 90 calendar days)	• Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and Best Corrected Visual Acuity (BCVA) worse than 6/60 (monocular) • Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and BCVA worse than 6/12 (binocular) • Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy with presence of bullae
Category 3 (clinically recommended to be seen within 365 calendar days)	• Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and BCVA worse than 6/12 (monocular) • Fuchs' endothelial dystrophy or pseudophakic bullous keratopathy and BCVA 6/12 (monocular) or better with functional impact on activities of daily living for consideration of surgery

Required information

- Reason for referral
- Details of the presenting condition including symptoms, nature, duration and impact on activities of daily living
- Provisional diagnosis
- Best Corrected Visual Acuity (BCVA) (in each eye) by optometrist, orthoptist or ophthalmologist
- Presence or absence of corneal bullae
- Previous management
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Previous ocular history
- Optometrist, orthoptist or ophthalmologist report, including refraction
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Driving status
- Social circumstances
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

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 or 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 and 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

Required information

- Reason for referral
- Details of the presenting condition including symptoms, nature, duration and impact on activities of daily living
- Provisional diagnosis

- Optometrist, orthoptist or ophthalmologist report including Best Corrected Visual Acuity (BCVA), refraction, intraocular pressure (IOP), visual field tests and disc assessment
- If the patient requires an interpreter (if so, list preferred language)

Additional information

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- 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 is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Lid lesions (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 or registrar.

- Periorbital skin cancer causing eyelid malposition with acute ocular pain and redness (i.e. signs or symptoms of microbial keratitis)

Out of scope (not routinely provided)

- Benign eyelid lesions not affecting vision or causing functional deficit
- Patients with minor cosmetic eyelid lesions

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Proven or suspected eyelid squamous cell carcinoma, sebaceous cell carcinoma, Merkel cell carcinoma or melanoma
Category 2 (clinically recommended to be seen within 90 calendar days)	• Proven or suspected eyelid basal cell carcinoma
Category 3 (clinically recommended to be seen within 365 calendar days)	• Benign eyelid lesions affecting vision or causing functional deficit

Required information

- Reason for referral
- Details of the presenting condition including duration, appearance, size, location of lesion, presence or absence of eyelid malposition, and/or corneal exposure
- Provisional diagnosis
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA)
- Pathology results of biopsy (if performed)
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Clinical image of lesion
- Changes in appearance of lesion
- Previous ocular history
- Refraction
- Driving status
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Social circumstances
- If the patient is at increased risk of falling

- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Macular hole or epiretinal membrane (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 or registrar.

- Nil

Out of scope (not routinely provided)

- Vitreo-macular traction not causing distortion or visual loss
- Asymptomatic, visual acuity 6/9 or better and no significant distortion
- Patient not willing to have surgery

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Full thickness macular hole with acute onset visual loss
Category 2 (clinically recommended to be seen within 90 calendar days)	• Epiretinal membrane with visual acuity worse than 6/12 • Symptomatic distortion (confirmed on Amsler grid) with abnormal fovea contour on optical coherence tomography • Lamellar macular hole
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic epiretinal membrane with visual acuity 6/9 to 6/12 and no distortion (confirmed on Amsler grid)

Required information

- Reason for referral
- Details of the presenting condition including symptoms and impact on activities of daily living
- Provisional diagnosis
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA)
- Retinal imaging or optical coherence tomography (OCT) results
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Refraction
- Retinal examination
- Previous ocular history
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Driving status
- Social circumstances
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Posterior capsular opacity (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 or registrar.	
• Nil	
Out of scope (not routinely provided)	
• Patient not willing to have YAG laser procedure	
Access and prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Posterior capsular opacity with Best Corrected Visual Acuity (BCVA) 6/60 or worse in both eyes
Category 2 (clinically recommended to be seen within 90 calendar days)	• Posterior capsular opacity with BCVA worse than 6/60 in one eye • Posterior capsular opacity interfering with management of other sight-threatening problems • Posterior capsular opacity in only functional eye
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic posterior capsular opacity
Required information	
• Reason for referral • Details of the presenting condition • Provisional diagnosis • Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA) (in each eye) • If the patient requires an interpreter (if so, list preferred language)	
Additional information (if available)	
• Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions) • Refraction • Previous ocular history • Timing of original cataract surgery • Functional impact on activities of daily living (ADLs) • Guardianship status • Professional driver with specific visual acuity requirements for employment • Driving status • Social circumstances • If the patient is at increased risk of falling • 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Pterygium (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 or registrar.

- Nil

Out of scope (not routinely provided)

- Asymptomatic pterygium or symptoms treatable with topical therapy (i.e. not threatening visual axis)
- Patient does not want surgery
- Pterygium ≤ 1 mm from limbus to apex

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Bilateral pterygia causing Best Corrected Visual Acuity (BCVA) 6/60 or worse in both eyes • Pterygium causing BCVA 6/60 or worse in only functional eye • Suspicion of ocular surface neoplasia
Category 2 (clinically recommended to be seen within 90 calendar days)	• Pterygium ≥ 3 mm from limbus to apex and visual axis is threatened (unilateral or bilateral)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic pterygium > 1 mm and < 3 mm from limbus to apex (unilateral or bilateral)

Required information

- Reason for referral
- Details of the presenting condition including symptoms, duration and functional impact on activities of daily living
- Provisional diagnosis
- Optometrist, orthoptist or ophthalmologist report, including size of pterygium from limbus to apex and Best Corrected Visual Acuity (BCVA) and refraction
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Refraction history
- History of symptoms management (e.g. lubricants)
- Previous ocular history
- Clinical image of pterygium
- Previous corneal topography results
- Professional driver with specific visual acuity requirements for employment

- Driving status
- Guardianship status
- Social circumstances
- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Ptosis (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 or registrar.

- Ptosis with anisocoria
- Ptosis with other neurological signs
- Sudden onset ptosis with or without diplopia
- Sudden onset ptosis with or without strabismus

Out of scope (not routinely provided)

- Patient does not want surgery

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Symptomatic ptosis involving visual axis
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic ptosis not involving visual axis

Required information

- Reason for referral
- Details of the presenting condition including symptoms, duration, sudden or gradual onset, unilateral or bilateral, and functional impact on activities of daily living
- Provisional diagnosis
- Description of ptosis (degree and involvement of visual axis or pupil)
- Oculomotor and pupil examination findings
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA)
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Clinical image of ptosis
- Previous ocular history
- Refraction
- Visual field test results
- Guardianship status
- Driving status
- Professional driver with specific visual acuity requirements for employment
- Social circumstances

- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made

Strabismus or ocular motility disorder (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 or registrar.

- Blow-out fracture
- Sudden onset limitation or reduction in ocular motility
- Sudden onset binocular diplopia
- Sudden onset strabismus

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Thyroid orbitopathy associated with recent onset strabismus with diplopia (cranial nerve palsy and/or neurologic disorder excluded)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Strabismus with diplopia impacting activities of daily living (cranial nerve palsy and/or neurological disorder excluded)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Longstanding strabismus with or without diplopia for conservative or surgical management

Required information

- Reason for referral
- Details of the presenting condition including symptoms, duration (acute or longstanding onset) and functional impact on activities of daily living
- Provisional diagnosis
- Details of previous treatment (e.g. type and duration)
- Details of previous investigations (e.g. imaging, pathology)
- Optometrist, orthoptist or ophthalmologist report, including Best Corrected Visual Acuity (BCVA) (in each eye) and refraction
- If the patient requires an interpreter (if so, list preferred language)

Additional information (if available)

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)
- Type of strabismus (constant or intermittent, unilateral or alternating)
- Previous ocular history
- Guardianship status
- Professional driver with specific visual acuity requirements for employment
- Driving status
- Social circumstances

- If the patient is at increased risk of falling
- 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
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made