Worcestershire Guide to direction of referrals

(Where to send what and when!)

2020

Worcestershire Local Optical Committee

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Worcestershire Guide to the direction of referrals

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Preface to second edition

The text has been extensively revised and updated, to improve clarity and understanding, particularly in response to the changing referral criteria and referral methods introduced by the National Health Service, following the decision by the Secretary of State for Health to switch off all fax communication with NHS institutions from 1st April 2020. The proliferation of the COVID-19 disease has resulted in a temporary suspension of the MECS service and the introduction of the COVID-19 Urgent Eye-care Service – CUES. Those conditions that would normally be referred to MECS but require referral to CUES have been annotated.

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The publisher may be contacted following the link on the Worcestershire Local Optical Committee website.

Introduction

This guide is primarily aimed at optometrists working as contractors or performers in the Worcestershire area of Herefordshire & Worcestershire CCG who are referring patients who are **registered with a GP practice in Worcestershire area of Herefordshire & Worcestershire CCG***. Where a patient is not registered with a Worcestershire GP*, please direct the referral to the patient's GP practice.

Please note that for "out of hours" urgent referrals patients will be directed to BMEC.

Worcestershire LOC request that a copy of this guide is issued to all performers by contractors in the Worcestershire area of Herefordshire and Worcestershire CCG. It is based on the agreed commissioning policy **"The Referral Guidelines and Clinical Thresholds for use in the Management of Common Ophthalmic Conditions (Primary and Secondary Care) April 2014 – Redditch and Bromsgrove CCG, South Worcestershire CCG, and Wyre Forrest CCG"** which has been adopted by Herefordshire and Worcestershire CCG for Worcestershire practices**.**

The route for referral is classified either as Immediate, Urgent, Routine, MECS *(CUES – during the temporary suspension of MECS*)* or GP.

Contents:

*For patients seen under CUES, the GP practice may be in Herefordshire or Worcestershire.

Quick reference by symptoms/signs

Classification of symptoms and signs

- Sore and Itchy
- Lumps and Bumps
- Red Eyes
- Gunky
- Painful
- Flashes and Floaters
- Loss of Vision

	Referral Route	Relative Urgency
Sore and itchy		
• Dry eye	MECS	
• Anterior Blepharitis	MECS	
• Posterior Blepharitis	MECS	
• Giant Papillary Conjunctivitis	MECS *(CUES)* – or refer back to CL fitter if appropriate	
• Allergy	MECS *(CUES)*	
• Interstitial Keratitis	Worcestershire Acute Pathway (MECS if uncertain)*	Urgent
• Herpes Simplex Keratitis	Worcestershire Acute Pathway (MECS if uncertain)*	Urgent
• Entropian	H&W CCG Routine Pathway	Routine
• Trichiasis	MECS *(CUES)*	
Lumps and bumps		
• Chalazion *(if over 6 months old)*	H&W CCG Routine Pathway	Routine
• Cysts & Stye	MECS	
• Lid Tumours	MECS – or Worcestershire Acute Pathway if melanoma	Urgent
• Viral lesions	Adult - H&W CCG Routine Pathway	Routine
	Child - Worcestershire Acute Pathway	Urgent
• Pterygium and Pingueculae	MECS – *Where pterygium invading cornea*	
• Blocked punctum	MECS – if Dacryocystitis- Worcestershire Acute Pathway	Urgent
• Cellulitis	Worcestershire Acute Pathway	Immediate
• Xanthelasma	*Refer to GP - serum cholesterol assessment as necessary*	
Red Eyes		
• Marginal Keratitis	MECS *(CUES)*	
• Keratitis – *others*	Worcestershire Acute Pathway	Immediate
• Allergy	MECS *(CUES)*	
• Viral Conjunctivitis	MECS *(CUES)*	
• Chlamydial Conjunctivitis	GP – *Be sensitive (Telephone call to on call doctor)*	Same day
• Acute Angle Closure Glaucoma	Worcestershire Acute Pathway	Immediate
• Acute Iritis (Anterior Uveitis)	Worcestershire Acute Pathway*	Urgent
• Episcleritis	MECS *(CUES)*	
• Scleritis	Worcestershire Acute Pathway	Urgent
• Sub-conjunctival haemorrhage	*No referral required unless posterior edge poorly defined*	
• Bacterial Conjunctivitis	MECS *(CUES)*	
• Pterygium	*Where invading cornea - H&W CCG Routine Pathway*	*Routine*
• Trauma	MECS *(CUES)* or Worcestershire Acute Pathway	Immediate
	(low severity) *(medium/high severity)*	
Gunky		
• Bacterial Conjunctivitis	MECS *(CUES)*	
• Bacterial Keratitis	Worcestershire Acute Pathway	Immediate
• Chlamydial Conjunctivitis	GP – *Be sensitive (Telephone call to on call doctor)*	Same day
• Dacryocystitis	Worcestershire Acute Pathway	Same day
• Anterior Blepharitis	MECS	

*During suspension of MECS recurrent episodes may be referred to CUES IP Optometrist

Quick reference by symptoms/signs	Referral Route	Relative Urgency
Painful		
• Anterior Uveitis	Worcestershire Acute Pathway*	Urgent
• Acute angle closure Glaucoma	Worcestershire Acute Pathway	Immediate
• Herpes Zoster Ophthalmicus	Worcestershire Acute Pathway*	Urgent
• Foreign bodies, abrasions or trauma	MECS *(Surface foreign bodies, light abrasions) (CUES)*	
	Worcestershire Acute Pathway *(deeper items)*	Urgent
• Recurrent Corneal Erosions	MECS *(CUES)*	
• Scleritis	Worcestershire Acute Pathway	Urgent
• Corneal ulcer	Worcestershire Acute Pathway	Immediate
• Cellulitis	Worcestershire Acute Pathway	Immediate
• Endophthalmitis	Worcestershire Acute Pathway	Immediate
• Hyphema/hypopium	Worcestershire Acute Pathway	Immediate
Flashes and Floaters		
• Innocent age-related cellular debris	MECS *(CUES) (Where diagnosis uncertain)*	
• Posterior vitreous detachment	MECS *(CUES)*	
• Retinal Detachment	MECS *(CUES) (Where diagnosis uncertain)*	
	(Where Certain) Worcestershire Acute Pathway	Urgent
Loss of vision:		
Acute total and acute partial loss of vision		
• Acute angle closure glaucoma	Worcestershire Acute Pathway	Immediate
• Consider vascular anomalies		
• Retinal		
– Arterial occlusion – embolism	Worcestershire Acute Pathway	Immediate
– Venous occlusion – CRVO	Worcestershire Acute Pathway	Immediate
– Venous occlusion – BRVO	Worcestershire Acute Pathway	Urgent
– Wet ARMD	Worcestershire Acute Pathway	Immediate
– Macular hole	H&W CCG Routine Pathway	Routine
• Proliferative Diabetic Retinopathy	H&W CCG Routine Pathway	Routine
• Nerve pathway vascular interrupts	Worcestershire Acute Pathway	Urgent
• Retinal detachment	Worcestershire Acute Pathway	Urgent
• Temporal Arteritis	Worcestershire Acute Pathway	Immediate
• Vitreous haemorrhage	Worcestershire Acute Pathway	Urgent
Transient loss of vision		
• Establish duration, one or both eyes?		
• Carotid or cardiac emboli?	Worcestershire Acute Pathway	Immediate
• Atrial fibrillation?	GP	
• Temporal Arteritis?	Worcestershire Acute Pathway	Immediate
• Nonarteritic anterior ischaemic optic neuropathy	Worcestershire Acute Pathway	Immediate
• Chronic angle closure Glaucoma?	H&W CCG Routine Pathway	Routine
Where IOP 40+	Worcestershire Acute Pathway	Immediate
• Papilloedema	Worcestershire Acute Pathway	Immediate
• Amaurosis Fugax	Worcestershire Acute Pathway	Urgent
• Neurological?	GP	
• Benign intracranial hypertension	GP	
• Migraine - does not require referral to MECS!	GP – *where medication indicated*	
Gradual vision loss of vision		
• Cataract	Patient's Chosen referral Centre	Routine
• Suspect primary open angle glaucoma	H&W CCG Routine Pathway	Routine
• Retinitis Pigmentosa	H&W CCG Routine Pathway	Routine
• Refractive error	Sight test	

*During suspension of MECS recurrent episodes may be referred to CUES IP Optometrist

Urgency of referral guide – *Quick Reference*

Immediate	Urgent
Angle Closure Glaucoma	Acute Iritis *
Anterior ischaemic Optic Neuropathy	Amaurosis Fugax
Bacterial Keratitis	Atopic Keratoconjunctivitis
Cellulitis	Bell's Palsy
Corneal Ulcer	BRVO *(reduction in visual acuity)*
CRAO/BRAO	Chlamydial Conjunctivitis
CRVO	Cystoid Maculae oedema *(Severe vision loss)*
Endophthalmitis	Dacryocystitis
Fungal Keratitis	Foreign Bodies *(Deep)*
Hyphema/Hypopium	Herpes Simplex Keratitis (HSK) *
Orbital Trauma/ Blow out fracture	Herpes Zoster Ophthamicus (HZO) *
Temporal Arteritis	Ideopathic Intra-cranial Hypertension
Trauma *(lacerations)*	Infantial Nystagmus
Wet ARMD	Interstitial Keratitis
3rd Nerve Palsy	Lid Melanomas
	Ocular Mucous Membrane Pemphigoid
	Orbital Tumour/Ocular Oncology
	Peri-orbital inflammation + Pain
	Retinal detachment
	Scleritis
	Toxic Retinopathies
	Trauma (moderate/severe)
	Vernal Keratoconjunctivitis Sicca
	Vitreous Haemorrhage
	4th & 6th Nerve Palsies

*During suspension of MECS recurrent episodes may be referred to CUES IP Optometrist

Urgency of referral guide – *Quick Reference*

Routine	MECS	GP
Blepharospasm *(Unexplained)*	Allergic Conjunctivitis *(CUES)*	Atrial Fibrilation
BRVO *(Peripheral – No vision loss)*	Anterior Blepharitis	Migraine *(Where medication indicated)*
Cataract	Bacterial Conjunctivitis *(CUES)*	Neurological disorders (Non-acute)
Chalazion *(Over six months duration)*	Blocked punctum *(Unless suspect Dacrycystitis)*	Xanthalasma *(Where Cholesterol Assessment required)*
Chronic Angle Closure Glaucoma *(IOP<30 mm Hg)*	Cysts & styes *(Hordeolum)*	
CRVO *(Late presentation)*	Dry Eye	
Ectropian *(Where surgical intervention Required)*	Episcleritis *(CUES)*	
Entropian	Flashes & Floaters *(CUES)*	
Infantile ptosis	Giant papillary conjunctivitis *(CUES)*	
Lid viral lesions	HSK *(where only suspect)* *(CUES)*	
Macular hole	HZO *(where only suspect)* *(CUES)*	
Non-proliferative & Proliferative Diabetic Retinipathy	Interstitial Keratitis *(where only suspect)* *(CUES)*	
Pigment Dispersion Syndrome	Lid tumours *(where only suspect)*	
Suspect Primary Open Angle Glaucoma *(Following local IOP repeat protocol & NICE Guidelines)*	Marginal Keratitis *(CUES)*	
Retinitis Pigmentosa	Posterior Blepharitis	
	Posterior Vitreous Detachment *(CUES)*	
	Pterygium *(where invading the cornea)*	
	Recurrent corneal Erosions *(CUES)*	
	Trauma & Foreign Bodies *(low severity only)* *(CUES)*	
	Viral conjunctivitis *(CUES)*	

Worcestershire LOC in association with Herefordshire & Worcestershire CCG

Ocular conditions referral guidelines for optometrists

Condition name	Signs/symptoms	Referral pathway and urgency			
		MECS	GP	Secondary Care (Hospital)	Urgency
Ocular adnexa and eyelids					
Necrotising Fasciitis	Peri-orbital infection with suspected skin necrosis	----	----	Worcestershire Acute pathway	Urgent
Lacerations/injury	Eyelids or canalicular	----	----	Worcestershire Acute pathway	Immediate
3rd nerve palsy	Sudden onset ptosis with motility restriction +/- pupil anomaly pain, double vision	----	----	Worcestershire Acute pathway *(will need onward referral to Neurologist)*	Immediate
Ptosis (lid margin over pupil when patient is relaxed)	1st presentation – Child under 8 yrs	----	----	Worcestershire Acute pathway	Urgent
	1st presentation – Adult (no miosis)	----	----	H&W CCG Routine Pathway	Routine
	Child 8 yrs + With pupil miosis (Horner's syndrome)	----	----	Worcestershire Acute pathway	Urgent
Eyelid neoplasia					
- Basal cell	Nodular – hard, pearly appearance	----	----	H&W CCG Routine Pathway	Routine
-	Nodulo-ulcerative , raised borders	----	----	H&W CCG Routine Pathway	Routine
	Sclerosing – flat, hardened plaque	----	----	H&W CCG Routine Pathway	Routine
- Squamous cell	Thickened scaly lesion often bleed	----	----	Worcestershire Acute pathway	Urgent

Ocular adnexa and eyelids		MECS	GP	Secondary Care (Hospital)	Urgency
- Sebaceous gland	Aggressive tumour – often related to recurrent chalazion or blepharo-conjunctivitis – usually arises from meibomian glands	----	----	Worcestershire Acute pathway	Urgent
- Lid melanomas	Irregularly pigmented lesions sometimes Inflamed and bleeding	----	----	Worcestershire Acute pathway	Urgent
Eyelid neoplasia	Where diagnosis is uncertain	Yes	----	----	----
Trichiasis (entropian absent)	lashes growing back and abrading cornea	Yes	----	----	----
Entropian (with or without trichiasis)	Eyelid margin turning inwards (more often female patient)	----	----	H&W CCG Routine Pathway	Routine
Ectropian (where severe exposure)	Eyelid turning outwards leading to punctual displacement, conjunctival thickening or corneal dryness	----	----	H&W CCG Routine Pathway *(No referral if not severe)*	Routine
Bell's palsy	Facial (VII) nerve palsy – brow ptosis cheek/mouth angle droop	----	----	Worcestershire Acute pathway	Urgent
Molluscum contagiosum	Single or multiple pearly indented peri-ocular lesion (poxvirus – may present as follicular conjunctivitis)	----	----	H&W CCG Routine Pathway	Routine
Floppy eyelid syndrome	Red eye, irritation, lid eversion on sleeping side at night	----	----	H&W CCG Routine Pathway	Routine
Chalazion – if recurrent/ chronic for 6 months+	"pea" size lesion within the base of meibomium gland	----	----	H&W CCG Routine Pathway *(No referral if under 6 months)*	Routine
Squamous papilloma	Pedunculated lid lesion	----	----	H&W CCG Routine Pathway	Routine

Ocular adnexa and eyelids		MECS	GP	Secondary Care (Hospital)	Urgency
Pillar cyst	Sebaceous/epidermoid or subcutaneous /dermal peri-ocular protruding mass	----	----	H&W CCG Routine Pathway	Routine
Stye - Hordeolum Externa	Common lid margin cyst - glands of Zeis or Moll, often irritable, often multiple, patients tend to rub lid margins *(Where very large dome shaped Fluid filled cyst on lid margin)*	Yes *(if persists)*	----	H&W CCG Routine Pathway	Routine
Xanthelasma	Yellow slightly elevated elongated deposits adjacent to medial canthus (middle aged patient) associated with hyperlipidaemia	----	Yes *(if hyperlipidaemia undiagnosed)*	----	
Blocked punctum	Swelling at nasal canthus, watering, discolouration & scaling below canthus	Yes	----	Worcestershire Acute pathway *(If Acute Dacryocystitis)*	Urgent
Cellulitis	Painful swelling of eyelids (usually pre-septal or orbital	----	----	Worcestershire Acute pathway	Immediate
Orbital Trauma – blow out fracture	History of recent trauma, associated signs, double vision (check motility)	----	----	Worcestershire Acute pathway	Immediate
Meibomium Gland Dysfunction	Blocked meibomium glands, tear foaming, lower corneal superficial punctate keratitis (SPK)	Yes	----	----	----
Blepharitis - Anterior	Sticky residue/crusting at root of eyelashes, redness and swelling of lid margins, irritation, burning sensation.	Yes	----	----	----
- Posterior	lid margin redness and swelling, tear foaming, lower corneal SPK, diffuse conjunctival injection, partial lash loss	Yes	----	----	----

Ocular adnexa and eyelids		MECS	GP	Secondary Care (Hospital)	Urgency
Ocular Rosacea	Thickened lids, chronic posterior blepharitis, tear film deficiency, telangiectasia of facial blood vessels, upper facial hyperaemia	Yes	---	---	----
Giant Cell Arteritis *(Temporal Arteritis)*	Headache, scalp tenderness, weight loss, jaw pain on chewing, transient vision loss, non-pulsatile thickened temporal arteries, RAPD, pale disc, papilloedema with/without haemorrhages, sometimes CRAO	----	----	Worcestershire Acute pathway	Immediate
External Eye Conditions					
Nystagmus	Usually infantile presentation, rhythmic or arrhythmic involuntary eye movements, usually lateral but may be vertical or other gaze directions, can be asymmetrical reduced VA, may be acute onset	----	----	Worcestershire Acute pathway *(Acute Onset)* H&W CCG Routine Pathway *(Asymptomatic)*	Urgent Routine
Strabismus	Usually managed under GOS/HES, refer newly diagnosed children and acute onset adults	----	----	H&W CCG Routine Pathway Worcestershire Acute Pathway	Routine *Urgent (Adult/child >5yrs acute onset with diplopia)*
4th and 6th nerve Palsies	Recent palsies – diplopia Longer term palsies – head tilt, face turn, gaze directed diplopia	----	----	Worcestershire Acute Pathway	Urgent
Conjunctivitis - Bacterial	Sticky discharge, red eye, watery mild lid oedema, initially unilateral	Yes *(CUES)*	----	----	----
- Acute Allergic	Sudden eyelid swelling, conjunctival swelling (chemosis), itching	Yes *(Only if recurrent)*	----	----	

External Eye Conditions		MECS	GP	Secondary Care (Hospital)	Urgency
- Seasonal Allergic	Red eye, itching, watering (clear) lid or peri-orbital oedema, slight chemosis, diffuse elevated papillae	Yes *(CUES)*	----	----	
- Viral (non-herpetic) (adenoviral)	Red eye, watery discharge, mild to moderate lid swelling, palpebral follicles (lower tarsal conj.), sub-epithelial infiltrates, initially unilateral (bilateral 5-10 days)	Yes *(CUES)*	----	----	
- Chlamydial	Acute or subacute red eye, irritation, mucopurelent discharge initially unilateral, large follicles in upper and lower fornicies, superior epithelial keratitis	----	Yes *(Same day)*	----	
- Medicamentosa	Initial improvement following use Rx eye drops – then redness, lid swelling, reduced vision, punctate corneal staining cornea/conj.	Yes *(CUES)*	----	----	
- Contact lens associated papillary (CLPC)	Itching and non-specific irritation mucus discharge, decreased lens tolerance, micropapillae, reduced vision, conjunctival oedema, GPC	Yes *(only if unable to refer back to CL prescriber)*	----	----	
- Giant papillary (GPC)	Chronic itching following exposure to allergen (usually contact lens). Large (jelly like) elevated papillae observed on eversion of upper lid, possible lid infiltrates	Yes *(CUES)*	----	----	

External Eye Conditions		MECS	GP	Secondary Care (Hospital)	Urgency
- Stevens-Johnson Syndrome	Bilateral conjunctivitis with or without bullae, possible SPK, mild anterior uveitis, affects young (children, adolescents young adults), lesions on limbs back of palms and elsewhere	----	----	Worcestershire Acute Pathway	Urgent
Keratoconjunctivitis					
- Vernal (Spring Catarrh)	Itching, stringy mucous discharge, photophobia, limbal oedema, Trandos dots, corneal punctate epithelial keratopathy GPC, subepithelial scarring, Age under 10 yrs, usually male	----	----	Worcestershire Acute Pathway	Urgent
- Atopic	Bilateral itching, watering, photophobia, limbal inflammation white stringy mucous, punctate corneal epitheliopathy, GPC, blurred vision, thickened eyelids	Yes *(if diagnosis uncertain)* *(CUES)*	----	Worcestershire Acute Pathway	Urgent
- Sicca (KCS) (Tear Deficiency) (Dry Eye)	Ocular irritation, FB sensation stringy mucous discharge, worse in smoke, wind or heat, usually bilateral, association with dry mouth (Sjogren's syndrome)	Yes	----	----	
- Adenoviral	See above, under conjunctivitis	Yes *(CUES)*	----	----	
- Superior Limbic	Middle-aged female, recurrent sensations of burning and FBs, photophobia, tearing and mucoid discharge. Associated with thyroid dysfunction (50%)	Yes *(CUES)*	----	----	

External Eye Conditions		MECS	GP	Secondary Care (Hospital)	Urgency
Ocular Mucous Membrane Pemphigoid	Px usually female ages 60-70 Chronic red eye (looks like Infectious conjunctivitis) Progression: conjunctivitis with subepithelial conjunctiival fibrosis possible cornea keratinization, symblephara, ankyloblepharon	----	----	Worcestershire Acute Pathway	Urgent
Subconjunctival Haemorrhage	Usually unilateral, limited at limbus, associations include recent eye surgery, trauma (often very mild) or warfarin/aspirin	---	---	---	
		No referral required unless posterior edge poorly defined			
Pterygium	raised triangular growth at 3 & 9 O'clock, usually nasal	Yes *(where invading cornea)*	----	----	
Pinguecula	Yellowish discoloured mass at 3 & 9 O'clock on bulbar conjunctiva	----	----	----	
		No referral required			
Chemical injuries	Acids, alkalis, solvent, detergent	----	----	Worcestershire Acute Pathway	Immediate
Corneal disease/injuries					
Corneal Abrasion and foreign bodies (Note History)					
- Abrasion	Acute discomfort, tearing, photophobia, possible redness, corneal staining	Yes *(CUES)*	----	----	

Corneal disease/injuries		MECS	GP	Secondary Care (Hospital)	Urgency
- Surface foreign Body	Acute discomfort, tearing, photophobia, localised redness, foreign body (maybe sub-tarsal – evert lid), epithelial FB, corneal staining	Yes *(CUES)*	----	----	
- Embedded Foreign body	Acute discomfort, tearing, photobphobia, localised redness, corneal staining, FB in stroma	----	----	Worcestershire Acute Pathway	Urgent
- Penetrating Foreign body	Acute discomfort and tearing, perhaps redness & photophobia, Seidel's sign	----	----	Worcestershire Acute Pathway	Urgent
Recurrent Corneal Erosion	Pain, tearing, redness, typically upon awakening, SPK to full thickness epithelial defects	Yes *(CUES)*	----	----	
Dry Eye	See Keratoconjunctivits Sicca above. Also less severe symptoms, itchy, irritable, exacerbated by poor blink rate, environment, reflex tearing, dellen at 3 & 9 O'clock	Yes	----	----	
Keratoconus	Irregular astigmatism, 'Scissors' topography, Munson's sign, thin/displaced central corneal cone, Fleisher ring	----	----	H&W CCG Routine Pathway	Routine
Corneal Ulceration	May present with or without pain. Association with herpes infection - simplex and zoster, bacterial infections, adenovirus, chlamydia, Epstein Barr, fungus, sarcoidosis, syphilis, contact lens complications	----	----	Worcestershire Acute Pathway	Urgent
		----	----	Worcestershire Acute Pathway	Immediate *(bacterial/fungal)* *(Contact lens with infection)*

Corneal disease/injuries		MECS	GP	Secondary Care (Hospital)	Urgency
Dystrophies	Map-dot-fingerprint, Cogan's (epithelial/Bowman's), Meesmann's (bilateral epithelial) Thiel-Behnke (curly fibre in Bowman's; Stromal – Lattice, Granular, Central Crystalline. Macular corneal; Posterior – Fuch's endothelial, Congenital hereditary, polymorphous (holes in Descemet's)	----	----	H&W CCG Routine Pathway	Routine
Band Keratopathy	May present with irritation, calcium deposits in basement layer of Bowman's and anterior stroma	Yes *(where irritation present)*	---	H&W CCG Routine Pathway *(If associated dystrophy present)*	Routine
Corneal degeneration and deposits					
- Climatic droplet Keratopathy	Spheroid degeneration of cornea mostly males and outdoor work	----	----	H&W CCG Routine Pathway	Routine
- Terrien's Marginal degn.	Slow progressive marginal superior nasal degeneration, bilateral, age 20 – 40 years male = female	----	----	H&W CCG Routine Pathway	Routine
- Lipid Keratopathy	"Fish eye" syndrome, lipid deposition from corneal vessels whitish deposit may encroach pupil area	----	----	H&W CCG Routine Pathway	Routine
- Saltzmann's Nodular degn.	Bluish/white nodules associated with irregular astigmatism, redness, irritation, blurred vision; initially epithelial/Bowman's, progress to stroma and corneal inflammation	----	----	H&W CCG Routine Pathway	Routine

Corneal disease/injuries		MECS	GP	Secondary Care (Hospital)	Urgency
- Arcus Senilis	Corneal annulus, bilateral, Symptom free.	----	----	----	----
		No referral required			
- Kayser-Fleisher Ring	Copper deposits near limbus superficial to Descemet's Symptom free	----	----	----	----
		No referral required			
- Vortex Keratopathy	Swirls of whitish/ghost striae anterior stroma, associated with systemic medications, most common Amiodarone. Symptom free	----	----	----	----
		No referral required			
- Corneal Farinata	Age-related (elderly) grey opacities in Descemet's membrane, small punctate or larger circular. Symptom free	----	----	----	----
		No referral required			
- Girdle of Vogt	Stromal chalky/white deposits adjacent to limbus Symptom free	----	----	----	----
		No referral required			
Keratitis					
- Interstitial (IK)	Irritation, tearing, photophobia, some redness; association with previous herpes infection - simplex and zoster, bacterial infections, adenovirus, chlamydia, Epstein Barr, sarcoidosis, syphilis.	----	----	Worcestershire Acute Pathway	Urgent
- Marginal	Localised red eye, whitish deposits superficial adjacent to limbus, associated with staphylococcal disease	Yes *(CUES)*	----	----	----

Corneal disease/injuries		MECS	GP	Secondary Care (Hospital)	Urgency
- Bacterial	Unilateral red eye, discomfort/pain, photophobia, discharge, tearing and blurred vision. Infiltrate/ulcer possible hypopyon	----	----	Worcestershire Acute Pathway *Worcestershire Acute Pathway (If hypoyon present)*	Urgent Immediate
- Fungal	Unilateral red eye, tearing, blurred vision, progressing pain and photophobia, possible raised IOP. Corneal opacity/ulcer	----	----	Worcestershire Acute Pathway	Immediate
- Acanthamoeba	85% CL wearer, swimming pools chronic discomfort, reduced CL wearing time, peri-limbal injection, peri-neural infiltrates to dense ring infiltrates, SPK.	----	----	Worcestershire Acute Pathway	Urgent
- Herpes Simplex (HSVK)	Discomfort/pain, eyelid rash, mild peri-limbal injection, epithelial dendritic ulcer, disciform oedema where stromal.	----	----	Worcestershire Acute Pathway	Urgent
- Herpes Zoster Ophthalmicus (HZO) (HZO)	Headache, ocular irritation, pain, skin lesions (ophthalmic branch trigeminal nerve), Hutchinson's sign (lesion at tip of nose), follicular or papillary conjunctivitis, micro-dendritic opacities, cells in AC	----	----	Worcestershire Acute Pathway	Urgent
Corneal Graft Rejection	1-2 years after graft, mild irritation and photophobia, small round subepithelial infiltrates (Bowman's), peri-limbal injection, AC cells and KP	----	----	Worcestershire Acute Pathway	Urgent
Ocular Hypertension	IOP >21mm.Hg, normal field and discs	*Follow NICE Guidelines*		H&W CCG Routine Pathway	Routine

		MECS	GP	Secondary Care (Hospital)	Urgency
Glaucoma					
- Acute Angle Closure	Painful unilateral red eye, poorly reacting vertically oval pupil, blurred vision, halos around lights, hazy cornea, headache, possible nausea and vomiting, pupil block	----	----	Worcestershire Acute Pathway	Immediate
- Chronic angle Closure	Intermittent headache and ocular discomfort (may awake Px from sleep), episodes of blurred vision and halos around lights, variable elevated IOP, narrow angles, high hypermetropia, disc cupping	----	----	H&W CCG Routine Pathway Worcestershire Acute Pathway	Routine Immediate *(If IOP 40+)*
- Primary Open	Follow local protocol for elevated IOPs, follow NICE guidelines for Ocular Hypertension, field defects, suspect discs	----	----	H&W CCG Routine Pathway	Routine *Earlier referral for suspect advanced glaucoma*
- Normal tension	IOP <24mmHg, suspicious discs, suspect glaucomatous fields	----	----	H&W CCG Routine Pathway	Routine *Earlier referral for suspect advanced glaucoma*
- Pseudoexfoliation Syndrome (PXF) & Pigment Dispersion Syndrome (PDS)	Transient visual blurring, often late presentation or incidental finding Possible elevated IOP; PXF – grey deposits between iris and lens, central transillumination deposits in AC angle; PDS – pigment displaced from iris deposited on endothelium, peripheral transillumination, pigment in AC angle.	----	----	H&W CCG Routine Pathway	Routine

Glaucoma		MECS	GP	Secondary Care (Hospital)	Urgency
Bleb infection	Redness, pain, photophobia reduced vision, discharge, inflammation around bleb	----	----	Worcestershire Acute Pathway	Urgent
Uvea/Pupil/Lens disorders					
Anterior Uveitis	Redness, pain, photophobia, poor vision, usually unilateral, flare & cells in AC, keratic precipitates, posterior synechiae, hypopyon	----	----	Worcestershire Acute Pathway	Urgent
Posterior Uveitis	Floaters and blurred vision, no discomfort or redness, systemic disease associations, possible hypopyon, macular oedema, disc swelling, snowbanking (periphery), vitreous haze and peri-vascular infiltrates, cotton wool spots, retinal pigment	Yes *(If diagnosis uncertain)* *(CUES)*	----	Worcestershire Acute Pathway	Urgent
Episcleritis	Usually unilateral red eye, mild/ moderate discomfort, no discharge	Yes *(CUES)*	----	----	----
Scleritis	Painful red eye, deep localised patch, Diffuse – small or large area, Nodular – part of inflamed sclera raised, Necrotising – thinned blue area (usually female)	----	----	Worcestershire Acute Pathway	Urgent

Uvea/Pupil/Lens disorders		MECS	GP	Secondary Care (Hospital)	Urgency
Endophthalmitis	Reduced vision, headache and/or pain, usually associated with post eye operation or keratitis or trauma also bacterial in elderly, diabetics, immunosuppressed, i.v. drug users. vitreous and/or AC inflammation, hypopyon, RAPD, may have poor view of fundus	----	----	Worcestershire Acute Pathway	Immediate
Adie's pupil *(Holmes-Adie tonic pupil)*	Usually unilateral, initially affected pupil is the larger, in long term becomes the smaller, constriction/ redilation to light very slow, near reflex often quicker, in early cases poor accommodation often present	Yes *(to confirm)*	----	----	
Argyll Robertson Pupil	Usually bilateral, but asymmetrical, small irregular pupils, association of neuro-syphilis	----	Yes	----	
Horner's syndrome	Unilateral miosis and ptosis (same side), heterochromia in infants, may be acute presentation in adult, anisocoria more apparent in dim illumination, possible carotid artery involvement in adults when acute presentation	----	----	Worcestershire Acute Pathway *(Adults and acute presentations)* H&W CCG Routine Pathway *(Later presentation children)*	Urgent Routine

		MECS	GP	Secondary Care (Hospital)	Urgency
FUNDUS					
Toxoplasmosis	May present with blurred vision, sometimes vitreous floaters. Active disease shows focal yellow-white area with well-defined border. Inactive disease classic old choroiditis pigmented lesion	----	----	H&W CCG Routine Pathway	Routine *(active disease)*
		Old choroiditis does not require referral			
Diabetic Retinopathy					
- Background (R1)	Scattered dot & blot haemorrhages, (where within 1 disc diameter fovea VA must be better than 6/12)	----	Yes *(Where patient not in screening system)*	----	
- Non-prolif/ Proliferative (R2)	BDR + Cotton wool spots, venous beading, New vessels at disc, new vessels elsewhere, sub-retinal haemorrhage, vitreous haem., rubeosis	----	----	H&W CCG Routine Pathway (BDR + Cotton Wool Spots and/or venous beading)	Routine
				Worcestershire Acute Pathway (All other R2 acute signs)	Urgent
- Maculopathy (M1)	BDR + haems within 1 disc diameter fovea and VA 6/12 or worse	----	----	H&W CCG Routine Pathway (even if patient in screening)	Routine
Branch Retinal Vein Occlusion	Painless VA reduction or symptom free, distinct branch retinal haems, possible cotton wool spots, macular oedema, disc & retinal new vessels	----	----	Worcestershire Acute Pathway	Urgent
Central Retinal Vein Occlusion	Unilateral painless acute loss of vision, pan-retinal haemorrhages, cotton wool spots, dilated/tortuous vessels, macular oedema, papilloedema, disc and retinal new vessels, rubeosis, RAPD	----	----	Worcestershire Acute Pathway	Urgent *(Routine if late Presentation)*

Fundus		MECS	GP	Secondary Care (Hospital)	Urgency
Branch Retinal Artery Occlusion	Unilateral painless acute loss of visual field, localised narrow arteries, whitening & oedema, emboli may be present, possible history of recurrent episodes	----	----	Worcestershire Acute Pathway	Immediate
Central Retinal Artery Occlusion	Unilateral painless severe loss of vision, retinal opacification, oedema & whitening, cherry red spot at macula, RAPD	----	----	Worcestershire Acute Pathway	Immediate
Hypertensive Retinopathy	Painless, often bilateral, flame shaped retinal haemorrhages, A/V nipping and right angle crossings, reduced VA where	----	*	H&W CCG Routine Pathway Worcestershire Acute Pathway	Routine *(*or to GP)* Urgent *(if severe, or cause of reduced)*
Nonarteritic Anterior Ischaemic optic neuropathy	Acute painless partial loss of vision, often no symptoms, sectorial optic disc swelling, flame haemorrhages, occasional macular star	----	----	Worcestershire Acute Pathway	Immediate
Central Serous Retinopathy	Unilateral, fairly quick disturbance of central vision, painless, usually unilateral, detachment of sensory retina between major arcades+/- pigment epithelial detachment	----	----	H&W CCG Routine Pathway	Routine
Retinitis Pigmentosa	Ret pig: post puberty/young to early middle aged adults, visual field loss, night blindness, intra-retinal bone-spicule pigmentation in mid-periphery, usually bilateral painless	----	----	H&W CCG Routine Pathway	Routine

Fundus		MECS	GP	Secondary Care (Hospital)	Urgency
Naevus	Painless, slate grey/discoloured flat area of fundus	Yes *(if > 5 disc diameters)*	----	----	
Choroidal Melanoma	Painless elevated tan or brown fundus lesion, often orange pigment edge, mushroom type appearance, affects late middle age white patients	----	----	Worcestershire Acute Pathway	Urgent
Other Ocular Oncology	Conditions include Choroidal metastasis, Retinoblastoma, Iris melanomas, malignant Conjunctival tumours	----	----	Worcestershire Acute Pathway	Urgent
	Retinal capillary haemangioma Choroidal haemangioma	----	----	H&W CCG Routine Pathway	Routine
Cystoid Macula Oedema	Painless reduction in vision often associated with post cataract surgery or YAG laser fluid accumulation in outer plexiform and inner nuclear layers, macular oedema	----	-----	H&W CCG Routine Pathway Worcestershire Acute Pathway	Routine Urgent *(if severe VA loss)*
Stargadt's Disease (JMD)	Poor central vision in children can present in young adults, beaten bronze macula, macular atrophy (Juvenile Macular Degeneration)	----	----	H&W CCG Routine Pathway	Routine
Best's Disease	Childhood/young adult, lower VA, macula shows "egg yolk" lesion, atrophy, unilateral or bilateral	----	----	H&W CCG Routine Pathway	Routine

Fundus		MECS	GP	Secondary Care (Hospital)	Urgency
Toxic Retinopathies	Chlorquinine and Hydroxychlorquinine: blurred vision, abnormal colour vision, scotomas, Bull's eye maculopathy, RPE atrophy.	----	----	Worcestershire Acute Pathway	Urgent
	Deferoxamine: decreased VA night blindness, scotoma, photopsia, irregular RPE pigmentation, disc oedema.	----	----	Worcestershire Acute Pathway	Urgent
	Phenpthiazines: blurred vision, night blindness, poor colour vision, fine/coarse pigmentary retinopathy affecting macula to mid-periphery	----	----	Worcestershire Acute Pathway	Urgent
Age Related Macular Degeneration (ARMD)					
- Dry	Gradual loss of central vision, no discomfort, difficulty reading, macular atrophy, pigment advancement/clumping, hard drusen; *(where soft, confluent drusen present – strong risk factor for developing wet ARMD)*	----	----	H&W CCG Routine Pathway *(When severe or geographic atrophy refer for LVA assessment)*	Routine *(only if concerns)*
	NB: This condition does not require referral unless there is concern regarding vision (Consider referral to LVA clinic if VA dropped back close to Partial Sight registration)				
- Wet *(Exudative)*	More rapid loss of central vision, distortion, symptoms usually uniocular, greenish grey lesion, sensory retinal detachment, soft drusen, pigment changes, sub-retinal haemorrhages, exudates no discomfort	----	----	Worcestershire Acute Pathway *(Follow protocol, complete appropriate referral form where required,* e-mail *to Worcester same day)*	Urgent

Fundus		MECS	GP	Secondary Care (Hospital)	Urgency
Macular Hole	Usually uniocular loss of central vision, no discomfort, small foveal circular lesion, 1/3 – 2/3 disc diameter, often idiopathic in late middle-aged women, may occur in trauma or high myopia or after cystoid macular oedema (particularly following YAG)	----	----	H&W CCG Routine Pathway	Routine
Posterior Vitreous Detachment	Acute onset flashes and floaters, vision unaffected apart from awareness of floaters that may be slight or severe, no discomfort, flashes initially intense, residual flashes more apparent in low light, Weiss's ring, retina satisfactory	Yes *(Same day)* *(CUES)*	----	----	
Retinal detachment	Usually unilateral, flashes (often persistent and independent of ambient light), floaters, shadow or curtain across vision, vision may be unaffected or severely reduced, retinal break or tear, sub-retinal fluid, increased hypermetropia/ decreased myopia, tobacco dust behind lens in anterior vitreous	Yes *(If diagnosis uncertain)* *(CUES)*	----	Worcestershire Acute Pathway (Birmingham if out of hours)	Urgent *(Note If macula on/off)* *(Immediate if macular on)*

		MECS	GP	Secondary Care (Hospital)	Urgency
Miscellaneous					
Aamaurosis Fugax	Transient visual loss without features of migraine, usually monocular, usually no fundus signs, *but check for retinal emboli*, possible carotid insufficiency	----	----	Worcestershire Acute Pathway	Urgent
Idiopathic Intra-cranial Hypertension	Headaches, transient visual disturbances often retrobulbar pain, occasional diplopia, sometimes loss of vision. Px often very high BMI, bilateral Papilloedema, occasional 6th nerve palsy	----	For Neurology (same day)	---	Urgent

Notes on referring patients

Please consider the following when referring a patient:

The patient must be registered with a GP practice in Worcestershire*, or a GP practice managed under the CCG representing Worcestershire (currently Herefordshire and Worcestershire CCG).
Where the patient's GP practice is outside Worcestershire then local protocols do not apply and the referral must be directed to the patient's GP.

*For CUES appointments only, during the suspension of MECS, the patient's GP practice may be in Herefordshire or Worcestershire.

When referring for suspect glaucoma on grounds of IOP alone, as detailed in NICE guidelines, ensure the local Glaucoma referral refinement protocol is followed. If a patient has elevated IOP and the optometry practice referring is not contracted to provide the Glaucoma refinement service, then the optometrist must refer the patient to a contracted practice in order for the Glaucoma refinement protocol to be followed.

If referring for an urgent consultation please ask the patient how they will travel to the hospital. Ensure that the patient knows the hospital address as well as the time of their appointment.

Some urgent referrals will be seen the following day (as directed by the triage nursing team) please ensure patients understand that it may not be necessary for them to be seen immediately. Correct patient expectation reduces anxiety.

Please write the reason for the referral and the relevant urgency in the subject header line of the e-mail and also record the reason on any private statement/prescription form. Please record these details in a fashion that will not induce alarm or further anxiety for the patient. The patient must give their consent for referral.

The reason for the referral and the urgency must be typed in the subject header line of e-mail.

Details to be included when sending nhs.net e-mail referral *(to be included on any attachments; GOS 18, Letters and Rapid Access Wet AMD forms)*

Patient details:

Surname First name Preferred name *(If applicable)* Title

Date of birth NHS Number *(please ask GP surgery if patient does not know NHS number)*

Hospital number (if patient already attends the hospital – if known, can be found on any NHS hospital reply)

Address *(including post code)*.

Contact telephone number (mobile and landline) – very important!

Other administrative information:

GP name, address and telephone number *(where available)*. When referring direct to a hospital always send a copy to the GP.

Optometrist's name, address, telephone and nhs.net e-mail address.
(please include referring optometrist's name in addition to signature)

Clinical information:

Patient's symptoms *(including duration and severity)*. Any appropriate history *(both patient and family).*
Current medication *(where known)*. Appropriate clinical findings and test results*.
The diagnosis/suspected diagnosis. The appropriate urgency of the referral.

Always include visual acuities and, if available, the refractive error (*refraction details are quite important!)*

***Note regarding test result information and triage service.**

When a patient is seen under the NHS General Ophthalmic Services and a referral to a medical practitioner (or hospital) is required the optometrist should complete a GOS 18 form (or letter equivalent). It is good practice where a visual field plot, fundus photograph, OCT scan or any other printed/recorded information is available, to include a copy of the recorded field plot, OCT scan or other recorded information with the referral.

The inclusion of OCT scans, visual field plots or other recorded information is not mandatory under the current GOS contract (2008 – part 8, paragraph 31). It is understood that it may not always be possible to provide a copy of the result of an additional test in the referral communication. The CCG's appointed NHS approved triage service should not reject a referral on grounds of failure to include visual field plot or OCT image. If an optometrist receives such a rejection, the optometrist should re-refer the patient siting any increased level of urgency caused by the delay. If the optometrist considers that the patient has suffered any avoidable ocular damage or permanent loss of visual function due to the delay, please inform a member of Worcestershire LOC in order for the compromise in patient care to be notified to the CCG.

Where a patient is seen under private contract for a sight test or additional tests (routine additional tests that the patient elects to purchase at the time of their sight test, either private or NHS GOS) and a referral into the NHS is required, the optometrist must include any visual field plot, OCT scan or other recorded information that has been purchased by the patient, unless the patient withholds consent.

Referral e-mail addresses

Wet ARMD

Rapid access fast track (complete appropriate form and forward via nhs.net)

Worcestershire Royal Hospital
e-mail: wah-tr.worcestershirehes@nhs.net

Gloucestershire Acute Hospitals
e-mail: ghn-tr.AMDteam@nhs.net

Worcestershire NHS e-mail addresses for referrals

- Urgent and cataract referrals: wah-tr.worcestershirehes@nhs.net
- Any Paediatric referrals: wah-tr.worcestershirehes@nhs.net
- Routine referrals: worcs.communityeyeservice@nhs.net
- Cataract Post Op Form: wah-tr.worcestershireHESpostop@nhs.net

Gloucestershire NHS e-mail addresses for referrals

- Booking office urgent/routine: ghn-tr.ophthalmologyappts@nhs.net
- Wet AMD dedicated e-mail: ghn-tr.AMDteam@nhs.net

Herefordshire NHS e-mail addresses for referrals

- Urgent referrals/advice letters: hereford.ophthalmologyadmin@nhs.net
- Routine and pre-cataract: directeyereferrals@nhs.net

Hospital contact details for referrals advice

Worcestershire urgent eye care service:

e-mail all acute referrals to: wah-tr.worcestershirehes@nhs.net

Kidderminster Treatment Centre

Monday to Friday 8.00am – 4.00pm (patients being seen until 5.00pm)

For acute referrals advice:

Tel: 01562 828826 (Direct line to triage nursing team)
(Triage nurse may ask optometrist to e-mail report to wah-tr.emergencycliniceyereferralktc@nhs.net)

For urgent referrals not needing to be seen immediately e-mail
wah-tr.worcestershirehes@nhs.net

Outside office hours: Referrals will be directed to **BMEC** (Birmingham Midland Eye Centre)
e-mail **swbh.team-eyereferrals-urgentcare@nhs.net**

Gloucestershire urgent eye care service:

Monday to Thursday 9.00am – 5.30pm, Friday 9.00am – 1.00pm

Ophthalmology GP/Optometrists phone line:

Tel: 0300 422 3578 (this line directs calls to eye casualty during office hours and redirects calls via main switchboard to duty ophthalmologist outside office hours)

COVID-19 Temporary suspension of MECS

CUES

From 01/06/2020 Herefordshire & Worcestershire CCG have suspended MECS for 6 months (with periodic review to monitor the appropriateness of the suspension)

The COVID-19 Urgent Eye-care Service (CUES) has been introduced from 01/06/2020 to run for 6 months (with periodic review to monitor the appropriateness of this service)

Referrals to hospitals for urgent eye care, using contact details as above, should be undertaken in accordance with the CUES guidelines whilst CUES is in operation. MECS will resume upon withdrawal of CUES

Hospital Addresses – *Please address to the Ophthalmology Department*		
Hospital	**Address**	**Telephone**
Alexandra Hospital Redditch	Woodrow Drive Redditch Worcestershire B98 7UB	Tel: 01527 503030
Birmingham and Midland Eye Centre	City Hospital Dudley Road Birmingham B18 7QH	Tel: 0121 507 4440
Cheltenham General Hospital	Sandford Road Cheltenham Gloucestershire GL53 7AN	Tel: 0300 422 2222
Gloucestershire Royal Hospital	Great Western Road Gloucester GL1 3NN	Tel: 0300 422 2222
Hereford County Hospital	Union Walk Hereford HR1 2ER	Tel: 01432 355444
Kidderminster Hospital and Treatment Centre	Bewdley Road Kidderminster Worcestershire DY11 6RJ	Tel: 01562 823424
Worcester Royal Hospital	Charles Hastings Way Worcester WR5 1DD	Tel: 01905 763333

Cataract referrals

Under NHS Choices system a patient may elect to be referred to any NHS approved provider for NHS cataract attention. Some approved private NHS providers are continuing to allow communication with fax as well as secure NHS mail. If a private provider does not have a secure NHS mail account to receive referrals then any referral must be made by fax or post for data security compliance. Some NHS approved private providers also offer a non-NHS cataract attention service. Should a patient desire, an Optometrist may refer a patient to a non-NHS private service provider, where a patient may be self-funding or covered by a Health Plan. Technically Optometrists are obliged to give the patient the full choice of NHS referral centres available in England. In reality, without a full directory published by NHS England being available to reference, this is not practical. The following is a list of centres within the vicinity of Worcestershire.

NHS cataract service providers

Worcestershire Acute NHS Hospitals: wah-tr.worcestershirehes@nhs.net

Gloucestershire Acute NHS Hospitals: ghn-tr.ophthalmologyappts@nhs.net

Hereford Victoria Eye Unit: directeyereferrals@nhs.net

BMI The Droitwich Spa Hospital:
St Andrews Road, Droitwich Spa,
Worcs WR9 8DN

No nhs.net
Fax: 01905 793 447
Tel: 0808 101 0336

Newmedica Eye Health Clinic:
C/o Aspen Medical Centre
Horton Road, Gloucester GL1 3PX

gloucestershire.cos@nhs.net
Fax: 0207 924 6262
Tel: 01452 596616

SpaMedica (Birmingham)
Apex House, Calthorpe Road,
Edgbaston, Birmingham B15 1TR
Postal Contact: SpaMedica Head Office
43 Churchgate, Bolton BL1 1HU

spamedica.referrals@nhs.net
Fax: 01204 441340
Tel: 0330 058 4281

Private cataract service providers:

Droitwich BMI, Newmedica and SpaMedica accept private referrals – contact details as above

Spire South Bank Hospital
139 Bath Road, Worcester, WR5 3YB

Fax: 01905 362 296
Tel: 01905 362 220

Lansdown Lodge
Lansdown Road, Cheltenham,GL51 6QL

Tel: 01242 522475

Nuffield Hospitals
Hereford & Cheltenham

www.nuffieldhealth.com/hospital

Lid margin disease

Patients with Anterior Blepharitis, Posterior Blepharitis, Mixed Blepharitis, Meibomium Gland Dysfunction, active recurrent external/internal Hordeolum or any other eyelid condition (e.g. Contact lens related Giant Papillary Conjunctivitis) must have the lid margin disease or underlying cause treated to resolution before cataract surgery can be undertaken. Optometrists are advised to manage and treat such conditions prior to referral for cataract assessment.

Contact lenses

Contact lenses should be removed prior to biometry and cataract surgery. Usually biometry will be undertaken on both eyes at first visit. Only if there is an absolute need to wear contact lenses, perhaps in the case of a very high prescription or underlying pathology e.g. stable long-standing keratoconus, a patient may remove the contact lens from the eye to be treated for the prescribed period whilst continuing to wear the contact lens in the other eye. Soft lenses should be removed for a minimum of 2 weeks, Gas Permeable lenses a minimum of 4 weeks and hard (PMMA) lenses for a minimum of 6 weeks prior to biometry and prior to surgery.

Exclusion criteria

Private NHS cataract service providers exercise exclusion of certain patients who may have underlying general health or ocular health conditions that may compromise or complicate the cataract surgery. Patients excluded from a private NHS provider should be referred to a NHS Acute Hospital Trust for evaluation of their suitability for cataract surgery, the excluded condition should be mentioned in the referral communication to the NHS Acute Trust. **Astigmatism** - Private NHS providers do not undertake limbal relaxation during cataract surgery, NHS patients with astigmatism >3.00D are better referred to an Acute NHS Trust. Non-NHS private providers may offer Toric IOLs.

The following exclusion criteria may be applied by BMI Droitwich, Newmedica & SpaMedica.
(Please contact the Private NHS provider if there are any questions relating to exclusion criteria)

BMI>40, weight>160Kg and unable to transfer independently
Need for hoists or other positioning equipment
Severe learning difficulties or dementia; affecting cooperation
Poor positioning issues, head tremor at rest, claustrophobia (unable to lie with drape over face)
Patients unable to lie flat for 20 minutes
Epileptics who have more than one grand mal seizure per month
Severe COPD – on oxygen therapy where SATS <92%
Active exposed skin infection
Uncontrolled systemic hypertension (Persistent diastolic >100mm.Hg)
Recurrent uveitis, brittle or end stage glaucoma
Patients with a defibrillating pace maker capable of delivering a shock to the patient
CVA within 3 months prior to surgery
Poorly controlled diabetes (BS > 20)
MRSA positive within 6 months prior to surgery
Malignant Hyperthermia
Raised IOP >30 mm.Hg (Newmedica)

Appendix 1 – Worcestershire Wet AMD Referral Form

Worcestershire Acute Hospitals (NHS) Trust

Referral Form for Rapid Access Wet Macular Degeneration Clinic

Referrals for other eye problems will not be accepted via this from (please refer separately).

Please type into this Microsoft Word document, then send via NHSmail (secure email) as a file attachment to wah-tr.worcestershirehes@nhs.net.

DATE OF REFERRAL Click here to enter a date.

PATIENT

Title and Name:	DoB:	NHS No.
Address:		
Contact Tel.		
GP Name:	GP Surgery:	

REFERRING OPTOMETRIST

Title and Name:	GOC No.
Tel:	Practice Address:

CURRENT SIGHT TEST – DATE Click here to enter a date.

	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA	Previous VA (date)
RE									
LE									

SIGNIFICANT PAST / FAMILY OPHTHALMIC HISTORY

SIGNIFICANT GENERAL HEALTH / MEDICATION HISTORY

Page 1 of 2

NEW SYMPTOMS

	Right Eye		Left Eye	
Visual loss in central visual field:	Yes - Duration:	No ☐	Yes - Duration:	No ☐
Spontaneously reported distortion:	Yes - Duration:	No ☐	Yes - Duration:	No ☐
Patient's own words:				

BEST VA (with trial lenses and / or pin hole) - Snellen or logMAR

Right Eye:	Left Eye:

MACULAR SIGNS

Sign	Right Eye		Left Eye	
Haemorrhage (preretinal/retinal/subretinal)	Yes ☐	No ☐	Yes ☐	No ☐
Exudate	Yes ☐	No ☐	Yes ☐	No ☐
Elevation	Yes ☐	No ☐	Yes ☐	No ☐

MACULA OCT (please only comment if confident)

	Right Eye		Left Eye	
IRF	Yes ☐	No ☐	Yes ☐	No ☐
SRF	Yes ☐	No ☐	Yes ☐	No ☐
PED	Yes ☐	No ☐	Yes ☐	No ☐
VMT	Yes ☐	No ☐	Yes ☐	No ☐
ERM	Yes ☐	No ☐	Yes ☐	No ☐

I HAVE PROVIDED THE FOLLOWING PATIENT INFORMATION

Macular Society Website Address ☐ **www.macularsociety.org**	Leaflet ☐ produced by: version / date:

COMMENTS

Notes

This form should only be used for wet AMD and other conditions complicated by choroidal neovascular membrane (such as high myopia). Please do not use this form for macula hole, diabetic maculopathy, retinal vein occlusion, post-operative cystoid macula oedema, etc. If the patient has suspected wet macular degeneration and also requires ophthalmology assessment for another problem, please make a separate referral for the other problem.

After receipt of this form the patient will be invited to an 'OCT Triage Clinic' – for which there are four possible outcomes: (1) follow-up in the Rapid Access (Macula) Clinic (2) follow-up in another hospital clinic (3) referral to The Practice Group (4) discharge to the care of the optometrist / GP.

Author Dr | M Gardner 23/9/19

Appendix 2 – Gloucestershire Wet AMD referral form

Gloucestershire Ophthalmology Service: **WET AMD RAPID ACCESS REFERRAL FORM**

For completion by Optometrist

Patient details Name: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

Hospital No (if known) _____

Address: _____

_____ Postcode: _____

Telephone: Home: _____ Work: _____ Occupation: _____

Referring Optometrist

GOC No: _____

General Practitioner

Name: _____

Practice Name: _____

Address: _____

_____ Postcode: _____

Telephone: _____

AFFECTED EYE:	**RIGHT ☐**	**LEFT ☐**
PREVIOUS HISTORY IN EITHER EYE		
Previous AMD	Right ☐	Left ☐
Myopic	Right ☐	Left ☐
Other:	Right ☐	Left ☐
Referral Guidelines		
PRESENTING SYMPTOMS IN AFFECTED EYE (one answer must be 'yes')		
Less than **3 month** history of:		
1. Visual Loss	Yes ☐	No ☐
2. **Spontaneously** reported distortion	Yes ☐	No ☐
3. Onset missing patch / blurring in central vision	Yes ☐	No ☐
FINDINGS Corrected VA (must be 6/96 or better in affected eye)		
1. Distance VA	Right	Left
2. Near VA	Right	Left
3. Macular drusen (either eye)	Right ☐	Left ☐
In the affected eye ONLY, presence of macular:		
4. Haemorrhage	Yes ☐	No ☐
5. Subretinal fluid	Yes ☐	No ☐
6. Exudate	Yes ☐	No ☐

CURRENT REFRACTION: Distance: R ..... L .....

Date: ..... Near: R ..... L .....

OTHER COMMENTS:	EMAIL TO ghn-tr.AMDteam@nhs.net

I request that my referring optometrist receives a report from the Hospital Eye Department: Yes ☐ No ☐

Patient's signature:	Print name:	
Optometrist's signature:	Print name:	**Date: / /**
Gloucestershire Royal Hospital: Central Booking Office, 8 Pulman Court,Great Western Road, Gloucester GL1 3ND		
Patients will be contacted within 48 hours of receipt of this referral, Monday to Friday and an appointment will be sent.	**Copy sent to GP:** **Yes ☐ No ☐**	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST AMD Rapid Access REFERRAL FORM – Version 6.3 Sept19

Appendix 3 - Kidderminster Ophthalmology Unit Telephone Triage Form

WORCESTERSHIRE ACUTE HEALTH CARE TRUST
KIDDERMINSTER OPHTHALMIC UNIT

TELEPHONE LOG SHEET

Person taking initial call..... **Person referring**.....

Date..... **Time**.....

Patients name..... **DOB**.....

Phone number..... **Unit No**.....

Address.....

Consultant..... **Handed over to**..... **TIME**.....

Reason for call.....

HISTORY **RIGHT EYE / LEFT EYE / BOTH EYES / ONLY EYE**

Last seen? Surgery? What /when?..... Next Appt..... Location of Notes.....

Current Treatment/drops?.....

Diabetes / Glaucoma / Other relevant medical / ocular history.....

Present symptoms:		**Duration of symptoms:**				
Pain	None	1.....5.....10				
Type	Itchy	Gritty	Burning	Stabbing	Other	
Nausea	None	Nausea		Vomiting		
Vision	Normal	Photophobia		Floaters	Decreased	
	Blurred	Double vision		Flashing lights	Shadow/curtain	No Vision
Conjunctiva	White	Yellow		Red		
Discharge	None	Watery		White/Creamy	Yellow/Green	Red
Eye lids	Normal	Swollen/Puffy		Red	Crusty	
Pupils	Normal	Round		Constricted	Dilated	Irregular
Movement	Normal	Painful		Difficult		

Discussed with .....

Outcome/Action taken.....

Referred to: Clinic appt KTC/WRH /ALEX Date & Time ..... **Patient informed YES**

lealth professionals signature ..... Date ..... Time.....

PLEASE FILE IN PATIENTS NOTES ONCE COMPLETE
THJ// HH Nov/2011

Frequently Asked Questions

1. ***What type of direct Referral is acceptable to HES, Worcestershire?***
   HES Worcestershire will *only* accept referrals for the following patients:-
   Emergency, Urgent (inc wet AMD), Cataract, and Routine 'out of area' (non-Worcestershire GP patients) and *Paediatrics

2. ***How should I refer into the HES, Worcestershire?***
   wah-tr.worcestershirehes@nhs.net
   Please state in the email header: **Urgent, Cataract, Paediatric or Routine 'out of area GP'** ***(Patients who are not registered with a GP in Worcestershire)***

3. ***Where do I refer routine referrals for Worcestershire GP registered patients?***
   ALL routine referrals (excluding Paediatrics) should be sent directly to OPEROSE (formerly TPG)
   worcs.communityeyeservice@nhs.net
   Operose will see routine glaucoma patients and book all other routine patients into the HES service

4. ***What if I send a routine referral, Worcestershire GP registered patient, directly to HES, Worcestershire?***
   Inappropriate referrals will be rejected, and returned to the Optometrist, via email, together with a cover document containing an explanation for rejection and guidance.

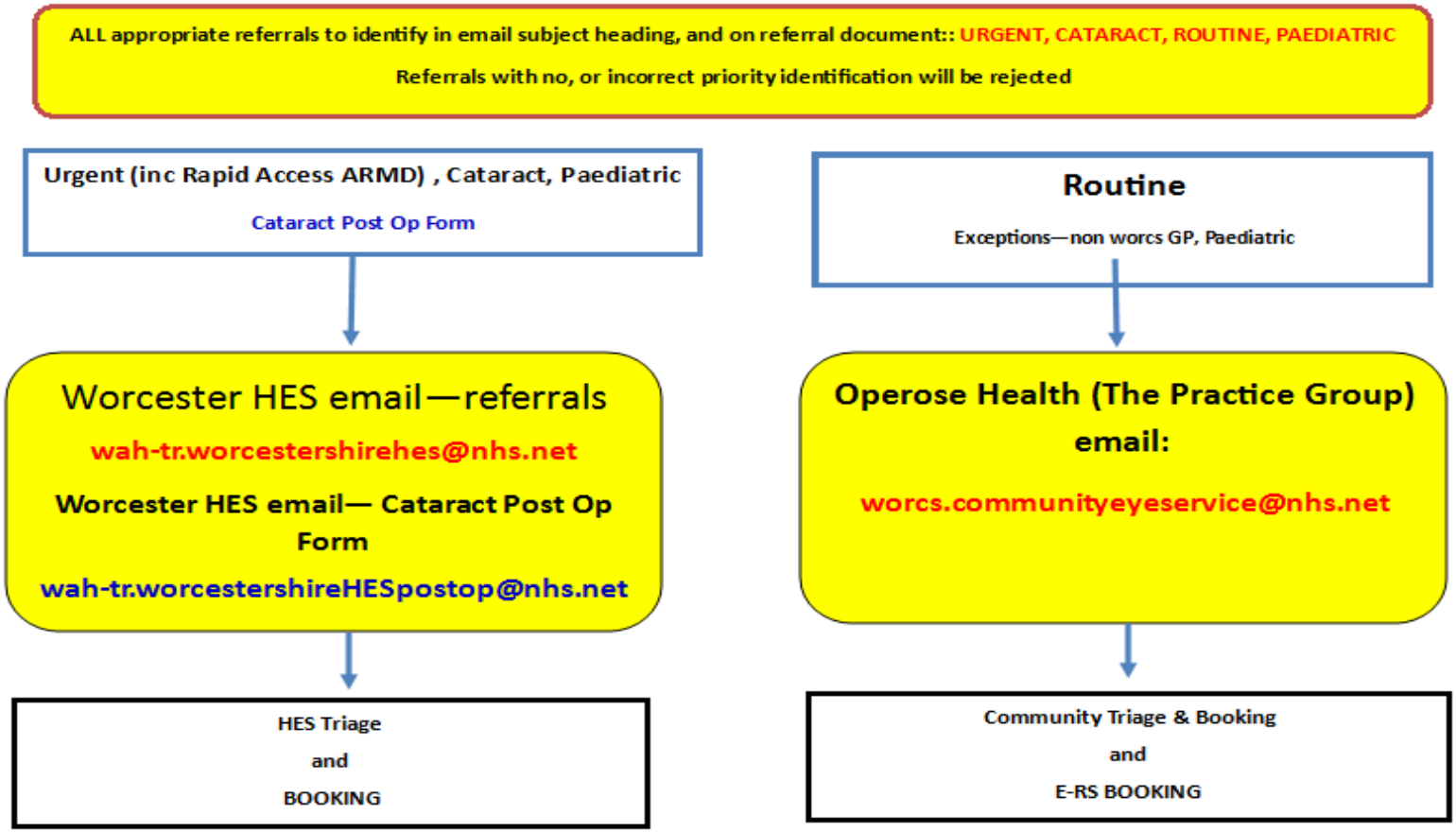
5. ***What if the patient is not under a Worcestershire GP?***
   Please refer into HES Worcestershire
   wah-tr.worcestershirehes@nhs.net

6. ***Where should I send the Cataract Post Op Form?***
   wah-tr.worcestershireHESpostop@nhs.net

Paediatric definition: As stated by NHS England (March 2017) Paediatric patient – is any patient below the age of 18

If your practice currently does not have a secure NHS email account please refer to https://support.nhs.net/knowledge-base/registering-optometrists/

Referral direction Flow chart – 2020



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Further reading:

Moorfields Manual of Ophthalmology (Ed. Timothy L Jackson) 2nd Edition;
Mosby Elsevier 2014

Oxford Handbook of Ophthalmology (Eds. Alastair K O Denniston, Philip I Murray) 3rd Edition;
Oxford Medical Publications 2014

The Wills Eye Manual (Eds. Adam T Gerstenblith, Michael P. Rabinowitz) 6th Edition;
Wolters Kluwer Health| Lippincott, Wiilams & Wilkins 2012

Ophthalmology An Illustrated Colour Text (Batterbury and Murphy) 4th Edition;
Elsevier 2019

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