

Wakefield Ophthalmology Referral Guidelines

February 2017

The ocular conditions listed in this guide are intended to reflect those that might be encountered in community optometrist practice. The document is not intended to be exhaustive. The suggestions for referral have been devised for guidance only. It does not remove the practitioner's professional responsibility to each patient, who should be dealt with on an individual case basis.

Although it is the Optometrists responsibility to judge the urgency of each referral, the conditions listed have been allocated a colour code as a guide which indicates the most appropriate level of care where a patient can be referred; this does not remove the patient's choice. The guide is as follows;

Using the guide

The eye conditions are separated into anatomical sections moving from the anterior eye to the retina with an additional section on orthoptics. The conditions are listed alphabetically. Each entry highlights the name of the condition, a indication of the degree of urgency (using a traffic light colour), and some additional diagnostic and referral information. The final box is split horizontally and shows the suggested referral destination in the upper box with urgency information in the lower box.

Bacterial Corneal Ulcer		Red eye, purulent discharge and light sensitive. Lesion is typically round with a white base.	Acute Clinic via fax
			To be seen within 24 hours

The traffic light guidance is as follows:



Acute Referral



Urgent Referral



Routine Referral

Referral destinations will depend on the nature of the condition and the urgency. For most referrals: **Acute & Urgent referrals** will be to Mid Yorkshire Hospital Trust Acute Eye Clinic based at Pinderfields Hospital, Wakefield.

Acute Helpline – 01924 541 196 **Referral Fax Line** – 01924 541 197

Routine Referrals can be sent by post or by fax to the Mid Yorkshire Hospital Trust based at Pinderfields Hospital, Wakefield or to one of 5 Community Ophthalmology Service providers.

<p>Treatment & Appointments Booking Centre, Pinderfields General Hospital, Aberford Road, Wakefield WF1 4DG Fax: 01924 542748 Tel: 01924 541169</p> <p>The Practice Ophthalmology Service Rose House, Bell Lane Office Village, Bell Lane Little Chalfont Amersham HP6 6FA Fax: 01977 502059 Tel: 01977 502 057</p> <p>Phoenix Health Solutions White Rose Surgery, Exchange Street, South Elmsall, WF9 2RD Fax: 01977 641290 Tel: 01977 642412</p> <p>The Grange Greenview & Kinsley Medical Centre, Highfield Road, Hemsworth, WF9 4DT Fax: 01977 619663 Tel: 01977 624270</p> <p>Living Care Northgate Medical Centre, Pontefract, WF8 1NF Fax: 01132 496024 Tel: 0113 2494655</p> <p>Mediscan Diagnostic Services Ltd Warrengate Medical Centre, Upper Warrengate, Wakefield, WF1 4PR Fax: 0161 820 1118 Tel: 0161 820 1123</p>

Additional Notes

Please note that the community service is only for patients aged 18 or over. All children and orthoptic referrals (under 18 years of age) should be sent to the hospital based ophthalmology service.

These guidelines also only relate to patients who have a Wakefield based General Practitioner.

As mentioned in the attached guidelines, a YAG laser capsulotomy service for Post Operative Capsular Opacification is also available from:

SpaMedica Unit 10, Silkwood Business Park, Ossett, Wakefield, WF5 9TJ

Referral can be made using a proforma available from the downloads section of the SpaMedica website at

www.spamedica.co.uk

or from the downloads sections of the Wakefield LOC website at

www.wakefieldoptometry.org.uk

Referral Guidelines

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 Acute Referral
Within 48hours

 Urgent Referral
Within 1 week

 Routine Referral

The Anterior Segment

Page One

Abnormal Iris Pigmentation		Most are benign. Beware of raised lesion, documented growth, pupil distortion, localised lens opacity, hyperchromic heterochromia.	Community Ophthalmology Service
			Routine
Acute Dacryocystitis		Excessive tearing, Red swollen mass medial to eye. Regurgitation under pressure. Patient may need oral antibiotics so referral destination will depend on access to GP.	GP / Acute Clinic
			Within 24 hours
Allergic Conjunctivitis		Sudden onset of itchy eye with a watery discharge, swollen lids and conjunctival hyperaemia. Attacks tend to be sudden, short and intense.	Treat in practice or advise patient to consult Pharmacist If poor response refer to GP
Bacterial Corneal Ulcer		Red eye, purulent discharge and light sensitive. Lesion is typically round with a white base.	Acute Clinic via fax
			To be seen within 24 hours
Bacterial Conjunctivitis		Red and painful eye with hyperaemia and purulent discharge.	Advise patient to consult Pharmacist. Patient should be advised to return to practice or consult GP if no improvement in 1 week
Basal Cell Carcinoma		Non healing lesion which is shiny, firm and pearly. Dilated blood vessels and slow growing over years. Can become ulcerative with rolled edges.	MY Appointments Centre
			Routine
Blepharitis		Very common inflammation of the lid margins due to Staphylococcus infection producing FB sensation, lid crusting and tear instability.	No referral usually necessary Advise on lid hygiene, use of topical lubricants and ask to return in two weeks.
Blepharitis Unresolved		For blepharitis that has failed to respond to improved lid hygiene / lubricants the patient may require additional therapy.	Community Ophthalmology Service
			Routine

Blepharospasm		Involuntary spasm of orbicularis & upper facial muscles. Factors include stress, driving, reading, bright light. Typically 60+	Community Ophthalmology Service
			Routine
Chalazion		Chronic inflammatory lesion causing blockage of meibomian glands. Round, firm lesion in tarsal plate. Affects any age. Refer if acute or associated problems	Usually no referral necessary. Refer to GP if acute or there are associated problems.
Corneal Dystrophy		Spontaneous, usually inherited, bilateral, corneal alteration <i>without</i> inflammation. Usually stationary, slowly progressive. Most present by 20 years old. Refer if vision becomes reduced.	MY Appointments Centre
			Routine
Dermatochalasis		Excessive skin folds. Commonly seen in over 60's. Eyelids feel "heavy". Only refer if patient has symptomatic field loss or if at least 50% or pupil is covered.	MY Appointments Centre
			Routine
Ectropion		Lid turned out, exposed conjunctiva, chronic infections. Eye is irritable, red, watery and unable to close properly.	MY Appointments Centre
			Routine
Entropion		Ocular irritation, foreign body sensation, epiphora, conjunctival hyperemia, superficial punctate epitheliopathy and, in severe or untreated cases, corneal ulceration.	MY Appointments Centre
			Routine
Episcleritis		Common, benign, normally self-limiting condition affecting superficial episcleral vessels. Typically few symptoms and no systemic associations. Refer however if symptoms are severe or persist.	Treat in practice with lubricants. If problematic then refer to Community Ophthalmology Service
Giant Papillary Conjunctivitis		Can be caused by repeated trauma or hypersensitivity to foreign material.	No referral necessary Address the problem and advise patient to consider Mast Cell stabilizers. Non-responders should be referred to Community Ophthalmology Service
Herpes Simplex Keratitis		Herpes Simplex or Zoster infection. Dendritic ulcer if epithelial or Disciform Keratitis if stromal.	Acute Clinic via fax
			To be seen within 48 hours
Herpes Zoster Ophthalmicus		Prodromal symptoms such as headache, fever, malaise, skin discomfort and rash, blurred vision, eye discomfort and eye pain. Signs are acute vesicular rash along fifth cranial nerve to midline.	Acute Clinic via fax
			To be seen within 48 hours

Hyphaema		Blood in anterior chamber Causes can be traumatic, Iatrogenic (IO surgery e.g. Trab) or a blood disorder eg thrombopenia.	Acute Clinic via fax
			To be seen within 24 hours
Iritis		Can be exogenous (trauma), endogenous (Ankylosing Spondylitis), infection (HZV) or Idiopathic (Majority). Signs can include injection, cells in AC, hypopyon (severe cases) KPs, and posterior synechiae.	Acute Clinic via fax
			To be seen within 24 hours
Iridoschisis		Rare condition where localised area of iris stroma is cleaved into two with the anterior atrophic portion becoming fibrils. Unknown aetiology Age-related degeneration associated with glaucoma	No referral necessary Requires a regular IOP check
Keratoacanthoma		Uncommon rapidly growing benign lesion. Appears as pink papule which grows rapidly for two months then static. Centre becomes hyperkeratotic and keratin filled.	Community Ophthalmology Service
			Routine
Keratoconus		Progressive disorder involving irregular conical shaped cornea. Usually bilateral and asymmetric. Watch for scissor reflex. Refer if vision falls below 6/9	MY Appointments Centre
			Routine
Marginal Corneal Ulcer		Hypersensitivity reaction to Staphylococcus exotoxins Common in blepharitis. Sub-epithelial infiltrate separated by a clear zone of cornea.	Acute Clinic via fax
			To be seen within 48 hours
Pinguecula		Yellow white deposit on the conjunctiva adjacent to the limbus. Has a direct correlation with UV exposure.	No referral necessary
Poor Lacrimal Patency		Clear watery discharge. Usually painless (unless dacryocystitis, mucocoele) Check with Fluorescein Clearance Test	Community Ophthalmology Service
			Routine
Pterygium		Wing shaped, fibrovascular tissue extending onto cornea. Signs include redness, irritation, dry eye feeling and decreased vision. Refer only if symptomatic or if lesion has progressed onto cornea by more than 2mm.	Community Ophthalmology Service
			Routine
Ptosis		Causes can be neurogenic, myogenic aponeurotic or mechanical. Referral will depend on degree of ptosis.	MY Appointments Centre
			Routine
		If acute onset refer sooner than routine.	Acute Clinic via fax
			To be seen within 48 hours

Scleritis		A granulomatous, potentially sight threatening inflammation of the sclera with possible complications including uveitis, keratitis and glaucoma.	Acute Clinic via fax
			To be seen within 48 hours
Squamous Cell Carcinoma		Less common than basal cell but much more aggressive and accounts for approximately 5% of all eyelid neoplasms. Typically affects elderly fair skinned people.	MY Appointments Centre
			Routine (within 4 weeks)
Trauma to anterior segment		Complications of trauma can be such things as displacement or malposition of the lens, hyphaema, corneal lacerations or foreign bodies.	Acute Clinic via fax
			To be seen within 24 hours
Trichiasis		Posterior misdirection of eyelashes. Common in blepharitis, trachoma, and following chemical injury. Complications can include punctate keratopathy and corneal ulceration. Only refer if symptomatic.	Community Ophthalmology Service
			Routine
Viral Conjunctivitis		Often associated with an URT infection, a common cold, and/or a sore throat. Symptoms include watery discharge and variable itch. Often starts in one eye but becomes bilateral. <u>Highly</u> contagious.	Usually no referral necessary.
			Acute Clinic via fax
		Patient should <u>only</u> be referred if there are secondary complications such as corneal epithelial deposits.	To be seen within 24 hours

Congenital Cataract		Usually diagnosed at birth or as an infant but if not permanent visual loss can occur. Degree of loss will depend on size and location. Refer only if a child under 7 years.	MY Appointments Centre
			Routine
Ectopia Lentis		Displacement or malposition of the lens. In the absence of trauma, ectopia lentis should raise suspicion for concomitant hereditary systemic disease or associated ocular disorders.	MY Appointments Centre
			Routine
Post Cataract Complications		These can be varied but if not sight threatening initially these need to be referred back to the cataract provider. If there are more serious complications then	Cataract Provider
			As appropriate
		If there are more serious complications such as endophthalmitis or iritis then these need to be dealt with as a matter of urgency.	Acute Clinic via fax To be seen within 24 hours
Posterior Capsular Thickening		Decreased vision is the main symptom which begins anywhere from a few months to many years after cataract surgery. Treated by YAG capsulotomy.	YAG Laser Provider *
			Routine
Pseudo-exfoliation	 	Anterior capsular changes that have implications for glaucoma. Note that normal IOP does not preclude prior IOP elevation. Evidence of or symptoms of glaucoma requires referral.	If no evidence or suspicion of glaucoma then no referral necessary.
			Community Ophthalmology Service
			Routine

* As of January 2017 there are two referral pathways for routine YAG laser capsulotomy:

- 1) Mid Yorkshire (refer via MY Appointments Centre)
- 2) SpaMedica – Wakefield (faxed referral using custom referral form) The form is available from the downloads section of the SpaMedica website at www.spamedica.co.uk or the downloads section of the Wakefield LOC website at www.wakefieldoptometry.org.uk

<p>Asteroid Hyalosis</p>		<p>Benign (mainly unilateral) condition where particles return to same position after movement. Treatment only in patients who are also being managed for retinal disease.</p>	<p>No referral necessary</p>
<p>PVD Uncomplicated</p>		<p>Patient presents with recent new floaters in the absence of continuing photopsia, anterior vitreous pigment cells or retinal breaks</p>	<p>No referral necessary</p>
<p>PVD Complicated</p>		<p>Patient presents with recent, sudden onset floaters or photopsia. Pigment cells in anterior vitreous or retinal break present.</p>	<p>Acute Clinic via fax</p>
			<p>To be seen within 24 hours</p>
<p>Synchysis Scintillans</p>		<p>Degenerative condition resulting in liquefied vitreous humour and the accumulation of cholesterol crystals. Appears as small white floaters that freely move in the posterior part of the eye, giving a snow globe effect.</p>	<p>No referral necessary</p>
<p>Vitreous Haemorrhage</p>		<p>Can give rise to profound vision loss if macula is obscured even by a small bleed. Causes include retinal detachment, proliferative Diabetic Retinopathy, Central Retinal Vein Occlusion and trauma.</p>	<p>Acute Clinic via fax</p>
			<p>To be seen within 24 hours</p>

<p>Hypoplastic Disc</p>		<p>The left disc is smaller than the right and blood vessels may enter the optic disc at an angle (giving an appearance of tilted disc). There may be associated nystagmus in the involved eye. There may be strabismus or afferent pupillary defect if the involvement is unilateral.</p>	<p>MY Appointments Centre</p> <hr/> <p>Routine (would normally be seen within 4 weeks)</p>
<p>Morning Glory Syndrome</p>		<p>Congenital condition where a central core of white glial tissue occupies the position of the normal optic cup, causing a white mass.</p> <p>Visual impairment depends on the development of the optic nerve where mild cases have limited colour perception to total blindness in advanced cases.</p>	<p>MY Appointments Centre</p> <hr/> <p>Routine</p>
<p>Myelinated Nerve Fibres</p>		<p>Non progressive, congenital condition. Where nerve fibers are encased in a sheath of myelin. NFL has white, feathery-edged appearance. Usually asymptomatic but extensive myelination can produce decreased vision and scotoma.</p>	<p>No referral necessary</p>
<p>Optic Disc Coloboma</p>		<p>Optic disc is vertically oval with excavation. Retinal vessels have abnormal origin and the choroid and iris may be involved. Condition may be bilateral.</p>	<p>Children: MY Appointments Centre</p> <hr/> <p>Routine</p> <hr/> <p>Adults: Community Ophthalmology Service</p> <hr/> <p>Routine</p>
<p>Optic Disc Drusen</p>		<p>The edge of the optic disc is irregular and there are lumpy, yellowish materials within the disc. The optic cup is absent and the blood vessels show an abnormal branching pattern. If you are confident of the diagnosis then referral is <u>not</u> necessary. If you have concerns then refer.</p>	<p>Community Ophthalmology Service</p> <hr/> <p>Routine</p>
<p>Optic Disc Haemorrhage</p>		<p>Often follows pattern of the nerve fibre layer. It is located anterior to or within the superficial tissue of the optic nerve head.</p> <p>If it starts over the optic nerve head but extends into the peripapillary retina, it is still considered an optic nerve haemorrhage. Causes can be glaucoma, PVD and diabetic retinopathy.</p>	<p>Community Ophthalmology Service</p> <hr/> <p>Routine</p>

Optic Disc Pit		Can be congenital or acquired, mostly asymptomatic. May be present with PVD or serous macular detachment. Asymptomatic pits require annual assessment.	MY Appointments Centre
			Routine
		Urgent referral is required if macula serous detachment is present or suspected.	Acute Clinic via fax
			Will be triaged appropriately
Optic Neuritis		Sudden loss of vision (partial or complete), or sudden blurred or "foggy" vision, and pain on movement of the affected eye. Possible loss some colour vision in affected eye, with colours appearing subtly washed out. Frequently there is no abnormal appearance of the nerve head though it may be swollen in some patients	Acute Clinic via fax
			To be seen within 24 hours
Swollen Disc		Optic disc margin is blurred and there is hyperaemia with or without splinter haemorrhage(s). Initially the vision, colour vision and pupillary responses are normal, but the blind spot is increased on field testing. Chronic cases have greater field and vision loss. Important Note : Please ensure that the referral states whether the patient is symptomatic or non-symptomatic	Acute Clinic via fax
			Patient will be triaged appropriately
Tilted Disc		The optic disc is elevated and the inferonasal disc is posteriorly displaced, giving an oval-appearing optic disc. There is an inferonasal peripapillary crescent and situs inversus of the vessels as they emerge from the disc. <u>Only</u> refer is there is a visual field defect	MY Appointments Centre
			Routine

Best Disease		Rare disease which is asymptomatic in early stages to decreased VA as low as <math><6/60</math> Has appearance of egg yolk like lesion at the posterior pole which might be replaced by scarring.	MY Appointments Centre
			Routine
Bulls Eye Maculopathy		Central foveolar hyper pigmentation surrounded by a depigmented zone giving appearance of a bulls eye lesion. Causes include chloroquine toxicity and Stargardts Disease. If non symptomatic and not on drugs of concern then routine referral	MY Appointments Centre
			Routine
		If patient is symptomatic or taking hydroxychloroquine then refer.	Acute Clinic via fax
			Patient will be triaged appropriately
Branch Retinal Artery Occlusion		Sudden onset loss of visual acuity or field of vision. May be preceded by shorter episodes from seconds to minutes. Sometimes embolus might be visible. This is always an emergency referral. <u>Always</u> investigate how long since the event occurred and include this in the referral as this will determine speed of hospital response.	Acute Clinic via fax
			Emergency Referral Response may depend on findings and on how recently the occlusion occurred
Branch Retinal Vein Occlusion		Patient presents with blurred vision, visual field loss, metamorphopsia or floater. It commonly occurs in 6 to 8th decade with risk factors of age, hypertension, glaucoma, Cardiovascular disease and diabetes. Lots of retinal haemorrhage, cotton wool spots, vessel tortousity, and retinal oedema.	Acute Clinic via fax
			Within 1 to 2 week
Central Retinal Artery Occlusion		Painless, sudden and severe loss of vision in one eye. Might be associated with a history of Amaurosis fugax. Can be as a result of atherosclerosis but it may be related to Giant Cell Arteritis in elderly. In younger patients it is due to collagen vascular disease, vasculitis, coagulopathy or embolic disease. Always note time since onset. This is always an emergency referral.	Acute Clinic via fax
			Emergency Referral Response may depend on findings and on how recently the occlusion occurred
Central Retinal Vein Occlusion		Presents with marked visual loss; the fundus showing retinal hemorrhages, dilated tortuous retinal veins, cotton-wool spots, macular edema, and optic disc edema.	Acute Clinic via fax
			Within 1 to 2 week
Central Serous Retinopathy		Unilateral round or oval macula detachment giving blurred vision and positive scotoma. VA improves with weak +ve lens. Typically affects young or middle aged males often Type A. Causes include stress, BP, steroid use.	Community Ophthalmology Service
			Routine

<p>CHRPE (Congenital hypertrophy of Retinal Pigment Epithelium)</p>		<p>Common benign lesion can be either typical (solitary or grouped) or atypical.</p> <p>Typical CHRPE are unilateral, flat, dark grey or black, well demarcated round or oval lesion 1 to 3 DD in size. Grouped lesions similar and often organised in a pattern simulating animal footprint.</p>	<p>No referral required</p>
		<p>Atypical lesions are multiple, bilateral, widely separated, frequently oval or spindle shaped lesions of variable size associated with hypopigmentation at one margin and have haphazard distribution. Systemic implications as associated with Familial adenomatous polyposis (FAP)</p>	<p>Community Ophthalmology Service</p> <hr/> <p>Routine</p>
<p>Choroidal Nevus</p>		<p>Present in about 5 to 10% of Caucasians but rare in dark skinned races</p> <p>Typical Nevus - It is usually post-equatorial, oval or circular, slate blue or grey lesion with detectable but not sharp borders. Dimensions are <3mm in diameter and <1mm in thickness. Associated with surface drusens.</p>	<p>No referral necessary Monitor with photographs if possible</p>
		<p>Atypical Nevus - might be amelanotic, a halo nevus.</p>	<p>MY Appointments Centre</p> <hr/> <p>Routine</p>
		<p>Suspicious Nevus - Symptomatic including blurred vision, metamorphopsia, field loss. Dimensions are >5mm in diameter and >1mm in thickness. Traces of surface orange pigment. Absence of surface drusens on a thick lesion or margin of the lesion at or near optic disc.</p>	<p>Acute Clinic via fax</p> <hr/> <p>Urgent</p>
<p>Cystoid Macula Oedema</p>		<p>Fluid accumulation in macular area that can be asymptomatic or have decreased VA, metamorphopsia and scotomas. Loss of foveal reflex and contour on high magnification.</p> <p>If cataract post-operative CMO then refer back to the cataract provider.</p>	<p>Acute Clinic via fax</p> <hr/> <p>Urgent</p>
		<p>If not post-operative CMO</p>	<p>Acute Clinic via fax</p> <hr/> <p>Urgent</p>
<p>Diabetic Retinopathy</p>		<p>Non-proliferative retinopathy. Always check with patient if they are under the DRSS and attend regularly.</p>	<p>Referral to DRSS</p>
		<p>Severe non-proliferative retinopathy or Clinically significant maculopathy</p>	<p>Refer to DRSS</p> <hr/> <p>Non Urgent</p>
		<p>Proliferative retinopathy DR needs urgent referral via Fax</p>	<p>HES</p> <hr/> <p>Urgent</p>
			<p>12</p>

Diabetic Macular Oedema		Retinal thickening or hard exudates within one disc diameter of the center of the macula. Clinically significant macula oedema may be asymptomatic but often involves decreased visual acuity metamorphopsia.	MY Appointments Centre
			Routine
Epiretinal Membrane		Membrane develops at the vitreo-retinal interface and appears as irregular macula light reflex or sheen. Best detected using RF light or OCT. Often mild metamorphopsia with slightly reduced VA but can be asymptomatic. If no visual problems, visual acuity is 6/12 or better and no vitreo-macular traction then monitor. Puckering of the inner retina does not require referral.	No referral necessary
		If visual acuity is less than 6/12 or vitreo-macular traction present (especially with 'table top') then refer.	MY Appointments Centre Routine
Lattice Degeneration		Present in about 8% of population and 40% of myopes over -5.00. Seen as sharply demarcated spindle-shaped areas of retinal thinning between equator and vitreous base. Round holes common.	Community Ophthalmology Service Routine
		Typically in 6 th /7 th decade and more common in females. Can appear as either a severe impairment of central vision or as a relatively asymptomatic deterioration. Ideally quantified with OCT if available. Any CMO should be referred by fax to acute clinic.	MY Appointments Centre Routine
Retinal Detachment		60% report photopsia and floaters caused by acute PVD and vitreous collapse. Signs include RAPD in advanced, low IOP, tobacco dust, Retinal breaks with detachment. After time patients notice peripheral visual field defect which may progress to involve central vision.	HES via helpline Acute
		If retinal vascular disease present such as non proliferative diabetic retinopathy, CRVO or BRVO. If flame shaped outside optic disc.	Community Ophthalmology Service Routine
Retinal Haemorrhages		If uncontrolled glaucoma or normal tension glaucoma present or especially if flame shaped and localized near the optic disc.	Community Ophthalmology Service As soon as possible
		If infection suspected, haemorrhages are white centred, papilloedema present or any intracranial disease is suspected.	Acute Clinic via fax To be seen within 24 hours

Retinoschisis		Present in 5% of population over 20yrs more in hypermetropes (70%) Due to splitting of nerve fibre layer mainly in infero-temporal periphery. Relatively immobile. If concerned or unsure of diagnosis refer.	Community Ophthalmology Service
			Routine
Retinitis Pigmentosa		Diagnosis is by bilateral night blindness with peripheral field defect. Presents with arteriolar attenuation, retinal bone spicule pigmentation and waxy pallor of disc.	MY Appointments Centre
			Routine
Tamoxifen Retinopathy		This is a specific anti oestrogen used in the treatment of selected cases of CA breast. Presents with bilateral, yellow crystalline ring-like macular deposits.	MY Appointments Centre
			Routine
Toxoplasmosis		Toxoplasma gondii is a parasite which is hosted in cats and livestock. Mainly asymptomatic finding with floaters or decreased VA but vitritis and retinitis in severe phase may give fog appearance. Old atrophic scars have pigmented borders.	MY Appointments Centre
			Non Urgent
			
Acute			
	Fog appearance or if immunocompromised	Acute Clinic via fax	
		Acute	

Esotropia Constant intermittent or accommodative		Refer if child is under 7 with refractive error corrected if present.	MY Appointments Centre
		Don't refer in over 7s, unless parents still wishes to attempt amblyopia treatment despite unlikely improvement or they wish to consider cosmetic surgery to improve appearance of squint. All referrals should be with any refractive error corrected.	Routine
Exotropia Constant		If patient is an infant and has a constant exotropia.	MY Appointments Centre Urgent
		Refer children under 7 but don't correct any low hypermetropic error. Refer at any age if they wish to have surgery for cosmetic reasons.	MY Appointments Centre Routine
Exotropia Intermittent		Refer children under 6. Children of 6 and older can be referred if amblyopic, but if vision good and equal only refer if divergence is noticed enough for parents/child to be considering surgery.	MY Appointments Centre Routine
Vertical Strabismus		Usually associated with ocular motility defects	MY Appointments Centre Routine
All squints		Any squint which is sudden onset, with or without symptoms, especially if associated with ocular movement problems needs referring as a priority. This applies especially if a nerve palsey is suspected	Acute Clinic via fax To be seen within 48 hours
Strabismic Amblyopia		Refer if child under 7 Children over 7 only if parents CLEARLY wish to attempt amblyopia treatment. Order any glasses as you refer to allow refractive adaptation to begin.	MY Appointments Centre Routine
Anisometropic Amblyopia		Refer if vision does not equalise with glasses ordered	MY Appointments Centre Routine
Ocular Motility Defects		Refer ocular motility defects as a routine if uncovered during your routine examination,	MY Appointments Centre Routine
		If defects are the reason for patients visit refer as priority.	Acute Clinic via fax To be seen within 48 hours

Convergence Insufficiency		Only refer if patient has symptoms.	MY Appointments Centre
			Routine
Nystamus Ptosis etc		Refer routinely unless sudden onset	MY Appointments Centre
			Routine
Refractive Errors		Only refer if vision fails to improve/equalise as expected, or the error is very high.	MY Appointments Centre
			Routine

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Our thanks to the Ophthalmology staff at Mid Yorkshire Hospital Trust for their help.