Sydney Hospital and
Sydney Eye Hospital

SYDNEY EYE HOSPITAL OUTPATIENT DEPARTMENT (OPD) REFERRAL CRITERIA

IMMEDIATE REFERRAL TO THE EMERGENCY DEPARTMENT
To discuss urgent referrals with the on-call doctor, please call switchboard on 9382 7111

- Sudden onset of new distortion of central vision
- Sudden loss of vision
- Severe/acute eye pain
- For other indications for referral, please see below

Referrals are accepted from GP's, Optometrists and other treating specialists, but please note an Optometrist or Ophthalmologist referral **is preferred**. An incomplete or vague referral may be returned to the patient with a request to see their Optometrist for re-referral at the Nurse Unit Manager's discretion.

Referrals are accepted by email and postal mail only.
Email – seslhd-sseh-eyereferrals@health.nsw.gov.au

1. **OPHTHALMOLOGY CONDITIONS NOT ACCEPTED** – the following conditions are not routinely seen at Sydney Eye Hospital and may be appropriately managed by a local Ophthalmologist, Optometrist or, GP, until they reach the clinical thresholds in these Referral Guidelines.

CONDITION	DESCRIPTION
Age-related Macular Degeneration (AMD)	Family history but asymptomatic Retinal Pigment Epithelial changes (previously called Dry ARMD) Drusen
Blepharitis	Itchy eyes No lid or corneal changes
Blepharospasm	Botox not available at SEH, consider Neurology referral
Cataract	Best corrected visual acuity better than 6/9 in both eyes (some exceptions)
Chalazion/Stye	Unless three times recurrent Without suspicion of malignancy
Conjunctivitis	ED referral only – do not refer to OPD

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Diabetic Eye Check	Newly diagnosed or established for routine fundus exam/screening Non-proliferative (background) diabetic retinopathy (minimal to mild)
Dermatochalasis (Excess Eyelid Skin)	Not obscuring visual axis Not resting on the lashes in straight ahead gaze
Dry Eye	Without trial of topical lubricants
Ectropion	Mild Without conjunctival involvement
Epiphora (Watery Eye)	Intermittent watery eye Not requiring surgical intervention
Epiretinal Membrane (ERM)	Asymptomatic VA 6/9 or better No significant distortion
Flashes and Floaters	Consider ED referral if not longstanding or history of retinal detachment/tear
Headache	Migraine with no ophthalmic symptoms Long-standing migraine with aura Tension headache with no ophthalmic symptoms
Lid Lesions	Small benign lesions BCC/SCC accepted
Paediatric	Squint/strabismus/refractive referrals only No lumps/bumps
Pterygium	Asymptomatic or symptoms treatable with topical therapy, vision unaffected and/or does not require surgery
Red Eye	ED referral if acute – do not refer to OPD
Refraction	For glasses check Refractive laser surgery (LASIK)
Trichiasis	With no corneal involvement Removal of eyelashes

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SYDNEY EYE HOSPITAL OUTPATIENT DEPARTMENT REFERRAL GUIDELINES

Diagnoses	Threshold criteria	Timeframe for clinic appointment
AMD Choroidal neovascularisation (CNV), or 'wet' AMD **No 'dry' AMD accepted**	Optometrist/Ophthalmologist referral only, including BCVA, retinal imaging/OCT, treating Ophthalmologist report outlining treatment regime and history CNV or 'wet' AMD	Urgent treatment for those not already receiving anti-VEGF treatment privately – each case individually triaged by fellow or MR consultant Routine treatment for those already receiving anti-VEGF treatment
Cataract	Optometrist/Ophthalmologist referral only, including BCVA, impact of symptoms, social circumstances, whether first or second eye, impact on drainage angle Better than or equal to 6/12 in cataract affected eye with no disabling symptoms Worse than or equal to 6/12 in one affected eye with disabling symptoms	IOL Waitlist Cataract pre-assessment clinic (CPAC) 6-9/12

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Posterior Capsular Opacity	Worse than or equal to 6/15 in cataract affected eye Worse than 6/9 vision and a professional driver Only functional eye or high falls risk Anisometropia 3.0dipotres or more White cataract	CPAC 4-6/12 CPAC 6-9/12 CPAC 3/12 General clinic next avail
Corneal	Optometrist/Ophthalmologist referral only	
Corneal decompensation (Bullous or endothelial keratopathy)		Urgent cornea clinic
Fuch's dystrophy		Semi-urgent cornea clinic
Keratitis	Red/irritated/reduced vision	Refer to ED
Pterygium/Pinguecula	Symptomatic – red/irritated/risk to vision	Routine cornea clinic
Keratoconnus	With hydrops Without hydrops	Refer to ED Semi-urgent cornea clinic
Dry Eye	Worsening despite standard treatment	Routine cornea clinic
Ocular squamous neoplasia (OSSN) or new pigmented lesions		Semi-urgent cornea
Diabetic Eye Disease	Optometrist/Ophthalmologist referral only	

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Diabetic Retinopathy Diabetic Macular Oedema Vitreous Haemorrhage	Retinal assessment including BCVA and refraction, Retinal imaging/OCT	
Diplopia	Acute onset	Refer to ED
Eye Infections/Inflammation		
Viral/bacterial conjunctivitis	Red eye/reduced vision/discharge	Refer to ED
Suspected uveitis/iritis	Decreased vision/elevated IOP/unilateral	Refer to ED
Suspected herpes simplex infection	Red eye, history of herpes, with or without reduced vision	Refer to ED
Suspected corneal ulcer		Refer to ED
Infection		Refer to ED
Suspected herpes zoster ophthalmicus with eye involvement	Vesicular rash, pain on forehead, red eye	Refer to ED
Suspected endophthalmitis	Recent surgery or intravitreal infection, red eye, pain, blurred vision	Refer to ED
Allergic Eye Disease	Severe or with decreased vision Severe itch Associated with atopy Children Adults	 Refer to ED Semi-urgent cornea clinic
Punctal stenosis	Watery eye	Routine Oculoplastics clinic

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Peri-orbital (Pre-septal) and Orbital cellulitis	Puffy eye, swollen lid++, unable to open eye, diplopia, loss of vision	
Eyelids	GP/Optometrist/Ophthalmologist referral	
Blepharospasm	Constant – see exclusion criteria above	Semi-urgent oculoplastic
Blepharitis	Severe and persistent with corneal and/or lid changes	Routine cornea clinic
Ectropion/Entropion	With conjunctival involvement or lid irritation	Semi-urgent oculoplastic
	Unmanageable pain/Corneal damage	Urgent oculoplastic
Dermatochalasis	Obscuring visual axis, resting on lashes in straight ahead gaze	Routine oculoplastic
Ptosis	Sudden onset with diplopia Unilateral with neurological signs Unilateral without neurological signs	Refer to ED Refer to ED Semi-urgent oculoplastic
	Bilateral long standing ptosis	Routine oculoplastic
Chalazion/Stye	Three times re-current	Semi-urgent oculoplastic
	Suspicion of malignancy	Urgent oculoplastic
Lid Lesions	BCC/SCC/non-specific, increasing in size or changing in colour	Urgent oculoplastic
Prosthesis	Non-specific, not increasing in size or changing in colour	Routine oculoplastic
	Infection Poor fit, needs replacement (10+ years)	Urgent oculoplastic Routine oculoplastic

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Eye Pain/Discomfort	GP/Optometrist/Ophthalmologist referrals	
Corneal or sub-tarsal foreign body (FB)		Refer to ED
Contact lens wearer		Refer to ED
Corneal ulcer		Refer to ED
Acute Angle Closure Glaucoma (AACG)	See 'Acute Glaucoma'	
Proptosis	Acute, chronic, endocrine related. Red eye with pain, pain on eye movements, reduction in vision Orbital mass	Refer to ED Urgent ocular oncology clinic
Optic Neuritis		Refer to ED
Pain on eye movements	With or without reduced vision	Refer to ED
Glaucoma	Optometrist/Ophthalmologist referral only, including BCVA, refraction, IOP, visual field tests and disc assessment (fundus imaging). **All new glaucoma referrals require full Orthoptic workup at SEH prior to allocation to clinic unless otherwise indicated by fellow/Consultant.**	
Glaucoma	With evidence of progression	Semi-urgent glaucoma
Increased IOP	Uncontrolled IOP >26mmHg Controlled IOP, not under care of private Ophthalmologist Controlled IOP, under care of private Ophthalmologist (wanting to transfer care into public system)	Urgent glaucoma Semi-urgent glaucoma Routine glaucoma

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Narrow angles	With controlled IOP	Routine glaucoma/general
Advanced/End-Stage Glaucoma		Urgent glaucoma
Acute Glaucoma	History of glaucoma, red painful eye, significant reduction in vision or loss of vision, photophobia, partly opaque cornea, hard and tender eye.	Refer to ED
Headache	GP/Optometrist/Ophthalmologist referrals	
Raised intracranial pressure	+/- neurological signs	Refer to ED
Giant cell arteritis	+/- vision loss, if pathology is suspected with confirmatory signs/symptoms e.g. raised ESR/CRP	Refer to ED
Headache with ocular pathology	Red eye, epiphora, proptosis, with diplopia or loss of vision And/or papilloedema	Refer to ED
Retinal Disorders	Optometrist/Ophthalmologist referral only	
Epiretinal membrane (ERM)	Symptomatic VA worse than 6/12 Patient wanting surgery	Routine VR clinic
Macular hole	Partial thickness Full thickness	Routine VR clinic Semi-urgent VR clinic
Retinal vein/artery occlusion • Central • Branch		Refer to ED Routine Inherited Eye Disease (Grigg)

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Inherited Eye Diseases including Retinitis Pigmentosa, Stargardt Disease		clinic + Orthoptics (HVF)
Vitreous haemorrhage	Known diabetic retinopathy New haemorrhage, no previous history	Urgent VR clinic Refer to ED
Central serous retinopathy (CSR)	Amsler grid changes New onset, no history	Urgent MR Refer to ED
Choroidal naevus		Semi-urgent ocular oncology
Intraocular melanoma		Urgent ocular oncology
Strabismus (Squint)	Optometrist/Ophthalmologist referral only	
Strabismus/lazy eye	With diplopia/suspicion of nerve palsy	Refer to ED
	With thyroid eye disease	Semi-urgent Orthoptics and oculoplastics
Esotropia (ET) (convergent)	Adults (longstanding) Children under age of 8 Children over age of 8	Routine squint Urgent squint Semi-urgent squint
	ET Acute onset	Urgent squint
Exotropia (XT) (divergent)	Acute onset - Children - Adult +/- ptosis	Urgent squint Refer to ED
	Long-standing adult	Routine squint
Trauma	Adnexal (lid) trauma	Refer to ED
	Blunt trauma	Refer to ED
	Chemical burn	Refer to ED

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	Foreign body Orbital fracture Retinal detachment Vitreous haemorrhage Hyphaema	Refer to ED Refer to ED Refer to ED Refer to ED Refer to ED
Uveitis	Acute +/- reduced vision, elevated IOP, posterior segment involvement. Uveitis in only good eye. Long-standing	Refer to ED Uveitis clinic – to be triaged by Fellow or consultant only
Visual Disturbance/ Vision Loss Sudden loss of vision Blurred vision (non-cataract) Neuro-ophthalmic disorders	 Acute onset Sudden unilateral or bilateral loss of vision, sudden lid ptosis, sudden double vision, sudden onset visual field loss, pain on eye movements, new onset anisocoria Hemianopia after stroke Review after rehabilitation for traumatic brain injury (TBI)	 Refer to ED Refer to ED Refer to ED Routine neuro-ophthalmology
Flashes/floaters	With reduced vision and/or cobwebs, curtain/shadow over vision	Refer to ED
Screening	Ethambutol Plaquenil	Orthoptics <1/12 from start of treatment Orthoptics routine

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