Ophthalmology
Patient Assessment & Referral Guide

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Information to include in referral letters (NO referral form needed)**:**

- ➔ If the patient's condition is acute or chronic
- ➔ Indications and symptoms
- ➔ Assessment and test results
- ➔ What has been tried to treat the patient's symptom(s)
- ➔ Current meds and any recent changes (pls indicate when meds were changed)
- ➔ Patient known medical history
- ➔ Patient known ophthalmic history

Letters can be sent by fax to Trail for emergencies (any cases that need to be seen urgently but not stat) for stat cases please call Trail clinic directly and to both Trail and Nelson for non-emergencies

****** All emergencies should be sent to Trail clinic ******

➤ Please refer to the patient assessment guidelines below prior to referral ➤

Symptom	Patient Assessment	Suggested Actions or Treatment
Flashes/ Floaters/ Veil	• check onset and frequency of symptoms • check vision and confrontational field test	• refer to optometry or ophthalmology for fundus exam
Eye Trauma	If perforating eye trauma	• if foreign body not visible, get at minimum X-ray to see depth of intraocular or orbital metallic foreign body • give antiemetic • put zero pressure on eye; put shell on eye • refer stat to on call ophthalmologist
	If superficial corneal foreign body with no acute trauma	• refer to ophthalmology if unable to remove foreign body or residual rust ring, start topical antibiotics to prevent infection in open wound
Loss of Vision	If acute painful or not painful: • check vision with acuity measurement and gross field test	• refer to ophthalmology • depending on etiology ophthalmologist may refer to family doctor for systemic evaluation
	If amaurosis fugax: • less than 1 minute complete vision loss in one eye • painless	• CBC, A1C, lipidic profile, blood pressure • 24-hour holter • heart and carotid ultrasounds • if over 55, check for GCA (symptoms + ESR/CRP) • if no vascular risk factors work up for thrombotic diseases and inflammatory diseases • refer to ophthalmology
	If chronic: • check vision	• refer to optometry for glasses adjustment • refer to ophthalmology for progressive pathologies (if patient known diagnosis)

Symptom	Patient Assessment	Suggested Actions or Treatment
Red Eye	If dry eyes: • symptoms - chronic, fluctuating blurry vision, red eyes, burning, scratching sensation	• start regular artificial tears (Systane, Blink or Refresh) minimum 4x a day • refer to optometrist
	If blepharitis or chalazion: • symptoms - chronic, red eyelids, fluctuating blurry vision, burning, or scratching sensation	• warm compress 10 mins 2x day, followed by washing with diluted baby shampoo or lid wipes, followed by massage of chalazion to drain • see Blepharitis Lid Hygiene Info Email to patient: ✉ • regular use of artificial tears, minimum 4x a day • refer to optometrist • refer to ophthalmologist for chalazion draining only after several months of conservative treatment and no longer inflamed
	If preseptal or postseptal cellulitis: • typically unilateral, cellulitis skin • preseptal - vision intact, conjunctiva normal • postseptal - decreased vision (please measure), chemosis and hyperemia of conjunctiva, proptosis, restricted eye movements	If preseptal: • start PO antibiotic typical Amoxicillin/ clavulanate 875/125 mg p.o. q12h for adults • refer to ophthalmology If postseptal: • get orbital and sinus CT, CBC, blood cultures, possible ophthalmic, neurological (if meningitis), ENT consultation (possible draining from sinuses) and infectious disease • start IV antibiotics

	If acute red eye:
	• check vision
	• check iop
	• do slit lamp exam to determine cause (if available)
		• can start topical antibiotics; would advise caution on starting steroids without optometrist or ophthalmic evaluation. Most commonly used antibiotics drop: ciloxan, ocuflox, tobrex, vigamox, zymar. Most common used ointment: erythromycin, tobramycine, ciprofloxacin
		• frequency depends on cause:
		  ○ Ex: Corneal abrasion, bacterial conjunctivitis: qid
		  ○ Corneal ulcer (especially induced): q 1 hour
		• refer to optometry or ophthalmology
		Note: patients with very well documented recurrent uveitis will need steroids (typical start is pred forte q 1 hour, maxidex ung hs and cyclogyl bid) however must be VERY confident this is a uveitis and not another bacterial or viral cause as steroid will make it worse. If in doubt, refer to optometry or ophthalmology for diagnosis prior to starting steroids. Patients will still need to be referred on an urgent basis to monitor inflammation, IOP and wean from steroids. Check IOP and amount of intraocular inflammation prior to start.

Other Symptoms	If strabismus	• refer to optometrist, often need glasses adjustment
	If diplopia: • check if monocular or binocular • check which nerve III, IV, VI • check if ptosis or anisocoria	• if isolated III with pupil involvement order CTA • if other binocular check CBC, A1C, lipidic profile, blood pressure and if over 55 check for GCA (symptoms + CRP/ESR) • refer to ophthalmology
	If eyelid lesions: • describe lesion • state urgency of lesion (if suspected malignancy or appears benign)	• if chalazion see above • all other lesions refer to ophthalmology with stated urgency if lesion appears malignant
	If screening for chronic disease: • plaquenil • diabetic	• please provide medications and how long patient has been on them • provide latest A1C • refer to ophthalmology