

# Ophthalmology Department

## Referral Evaluation and Management Guidelines

## OPHTHALMOLOGY OUTPATIENTS REFERRAL EVALUATION AND MANAGEMENT GUIDELINES

For Emergency Referrals: Phone on call Ophthalmology registrar on (07) 3636 8111  
Send patient to the RBWH Department of Emergency Medicine (DEM)

For all other referrals

- CATEGORY 1 – APPOINTMENT WITHIN 30 DAYS DESIRABLE
- CATEGORY 2 – APPOINTMENT WITHIN 90 DAYS DESIRABLE
- CATEGORY 3 – APPOINTMENT NOT REQUIRED WITHIN 90 DAYS
- NOT ROUTINELY SEEN

**Clinic times:**

Out-patients – Monday to Friday 8.00am to 4.30pm

Eye Casualty (Eye Clinic) – Monday to Friday 8.00am to 3pm – appointment not required

All urgent cases **must be discussed** with the on call Ophthalmology Registrar. Contact through RBWH switch (07) 3636 8111 to obtain appropriate prioritisation and treatment. Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Eye Clinic: (07) 3636 5433

*When possible all non-metropolitan patients referred to RBWH must include travel, accommodation, and escort arrangements. An inpatient bed may not be possible or relevant once the patient has been assessed by RBWH Ophthalmology department.*

**All referrals must be completed on the attached referral sheet.**

Referrals containing insufficient information or that are illegible will be returned to the referral centre. This may result in delayed appointment/treatment for your patient.

Priority	Criteria	Examples
<b>Emergencies – phone Ophthalmology Registrar as above or send to RBWH Department of Emergency Medicine</b>	Trauma not able to be treated conservatively	<ul style="list-style-type: none"> <li>• Surgical trauma to the lids, orbit, ocular structures</li> <li>• Penetrating eye injuries</li> <li>• Retained intraocular foreign bodies</li> <li>• Hyphaema</li> <li>• Chemical burns</li> </ul>
	Painful red eye with significant loss of vision	<ul style="list-style-type: none"> <li>• Corneal ulcer</li> <li>• Acute Glaucoma</li> <li>• Infections</li> <li>• Iritis</li> </ul>
	Infective conditions	<ul style="list-style-type: none"> <li>• Herpes zoster/simplex</li> <li>• Acute dacryocystitis</li> </ul>

	Sudden severe loss of vision	<ul style="list-style-type: none"> <li>• Ischemic ocular conditions e.g. temporal arteritis</li> <li>• Optic neuritis</li> <li>• Retinal detachment</li> </ul>
<b>Category 1</b>	Sudden loss of vision	<ul style="list-style-type: none"> <li>• Retinal detachment</li> <li>• Retinal/Vitreous haemorrhages</li> </ul>
	Neurological conditions threatening permanent damage if treatment delayed	<ul style="list-style-type: none"> <li>• Disc oedema</li> <li>• Other cranial nerve palsy</li> <li>• Glaucoma</li> <li>• Bell's palsy</li> </ul>
	Diabetic conditions with sudden or severe loss of vision	<ul style="list-style-type: none"> <li>• Retinopathy</li> </ul>
	Painful red eye with loss of vision	<ul style="list-style-type: none"> <li>• Iritis</li> <li>• Mature cataract</li> <li>• Herpes zoster/simplex</li> </ul>
	Traumatic conditions	<ul style="list-style-type: none"> <li>• Corneal foreign bodies</li> <li>• Orbital blow-out fractures</li> <li>• Corneal abrasions</li> <li>• Blunt trauma</li> </ul>
	Progressive/invasive cancers	<ul style="list-style-type: none"> <li>• Intraocular malignancy</li> </ul>
	Infective conditions	<ul style="list-style-type: none"> <li>• Acute dacryocystitis</li> <li>• Unresponsive conjunctivitis</li> </ul>
	Chronic impairment of visual function	Bilateral "hand movement" cataracts
<b>Category 2</b>	Low grade non-progressive neoplasms	<ul style="list-style-type: none"> <li>• Benign tumours and low grade BCC</li> </ul>
	Moderately progressive diabetic conditions	<ul style="list-style-type: none"> <li>• Maculopathy</li> </ul>
	Miscellaneous conditions threatening permanent damage if treatment is delayed	<ul style="list-style-type: none"> <li>• Entropion</li> <li>• Severe ectropion</li> <li>• Cicatrizing disease</li> </ul>
	Orbital disease	<ul style="list-style-type: none"> <li>• Proptosis – displacement of globe</li> <li>• Thyroid eye disease</li> </ul>
	Neurological conditions	<ul style="list-style-type: none"> <li>• Headaches with ocular symptoms/signs</li> <li>• Painless diplopia</li> </ul>

<b>Category 3</b>	Chronic impairment of vision	Cataracts and media opacities <ul style="list-style-type: none"> <li>• AMRD</li> <li>• Open angle glaucoma (eye not red)</li> </ul>
	Chronic non-sight threatening conditions	<ul style="list-style-type: none"> <li>• Pterygium</li> <li>• Cosmetic ptosis</li> <li>• Cosmetic squint</li> <li>• Ectropion</li> <li>• Some ocular plastic procedures</li> <li>• Epiphora (watering eye)</li> </ul>
	Diabetic conditions	<ul style="list-style-type: none"> <li>• Non vision threatening</li> </ul>
	Refractive error with co-morbidity	<ul style="list-style-type: none"> <li>• Keratoconus</li> <li>• High myopia</li> </ul>
<b>NOT ROUTINELY SEEN</b>	The following conditions are not routinely seen at the RBWH Ophthalmology Department	
	<p>Adult refractive conditions alone, without co-morbidity.                  Minor cosmetic abnormalities without any other pathology                  Presbyopia without co-morbidity.                  Children under the age of 16 – contact the RCH Ophthalmology Department: (07) 3636 7547</p> <p>Routine screening for:</p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Family History Glaucoma</li> <li>• Drug toxicity</li> <li>• Headache</li> <li>• Cataracts with best corrected visual acuity (BCVA) of 6/9 or better</li> </ul>	

## Referral Evaluation and Management Guidelines

All referrals must be completed on the attached referral sheet. Referrals containing insufficient clinical information or those which are illegible will be returned to the referral centre, this may result in delayed appointments/treatment for your patient.

All referrals must be sent to the patient's nearest public ophthalmology service

**Please continue to monitor patient's condition until a new case appointment is offered. Re-refer if clinical condition deteriorates.**

Diagnosis	Evaluation	Management	Referral Guideline
<b>Eye problem</b> <ul style="list-style-type: none"> <li>• Cataracts</li> <li>• Diabetes</li> <li>• Diplopia</li> <li>• Infections</li> <li>• inflammations</li> <li>• Eye lid malposition</li> <li>• Glaucoma</li> <li>• Loss of vision (LOV) – non-cataract</li> <li>• Ophthalmologic headache</li> <li>• Orbital pain</li> <li>• Squint / vision problems</li> <li>• Trauma</li> <li>• Watery eye</li> <li>• Dry eye</li> <li>• Plaquenil Screening</li> </ul>	Although history & physical examination is required to determine the specific diagnosis the following information must be contained on the referral: <ul style="list-style-type: none"> <li>• Best corrected visual acuity (BCVA) – with distance glasses or pinhole (PH)</li> <li>• Ocular history</li> <li>• Relevant medical history</li> <li>• Relevant family/social history</li> <li>• Fundoscopy findings where appropriate</li> </ul>	Specific treatment depends on the specific problems identified.  <b>Note:</b> <b>Topical Steroids MUST ONLY BE PRESCRIBED FOLLOWING DISCUSSION WITH OPHTHALMOLOGIST</b>	All referrals <b>must</b> contain reference to patient's GP  The referral should contain: <ul style="list-style-type: none"> <li>• Patient's current contact details, including home and mobile phone numbers, current address and or email address</li> <li>• Physical findings, including: BCVA if reduced check with pinhole</li> <li>• Details of any previous optometric assessments e.g. refraction, field tests.</li> </ul>
Diagnosis	Evaluation	Management	Referral Guideline
<b>CATARACTS</b>			
	<ul style="list-style-type: none"> <li>• BCVA (with distance glasses)</li> <li>• Last optometric assessment (or optometrist contact details)</li> <li>• Level of visual impairment (ADL, occupation, driving, educational)</li> <li>• Social circumstances</li> </ul>	<ul style="list-style-type: none"> <li>• If appropriate, optometric assessment i.e. new glasses</li> <li>• If vision in each eye is 6/6 or better review in 6 months unless occupational factors override e.g. Passenger service licence.</li> </ul>	<ul style="list-style-type: none"> <li>• Recent optometric assessment within 6 months prior to referral including refraction.</li> <li>• If vision in either eye is worse than 6/9</li> </ul> Maintain ongoing review until an appointment is offered. Re-refer if

	<ul style="list-style-type: none"> <li>Whether first, second eye or both eyes.</li> </ul>	<ul style="list-style-type: none"> <li>Consider appropriate domiciliary aides or assistance</li> </ul>	clinical condition deteriorates.
<b>DIABETICS</b>			
	<p>IDDM/NIDDM</p> <ul style="list-style-type: none"> <li>Duration/new case</li> <li>Regime/stability</li> <li>Previous ocular examination</li> <li>Systemic diabetic disease</li> <li>Risk factors – smoking, hypertension, pregnancy.</li> </ul>	<p>Asymptomatic NIDDM screening by;</p> <ul style="list-style-type: none"> <li>GP</li> <li>local ophthalmologist or optometrist</li> </ul> <p>IDDM/symptomatic DM New IDDM at 5 years</p>	<p>Prompt referral for the following:</p> <ul style="list-style-type: none"> <li>Progressive/intermittent LOV,</li> <li>pregnancy,</li> <li>multiple risk factors</li> </ul> <p>Maintain ongoing review until an appointment offered. Re-refer if clinical condition deteriorates.</p>
<b>DIPLOPIA</b>			
<b>Acute – painful</b>			Refer immediately. Phone ophthalmology registrar or send to RBWH DEM
<b>Acute – painless</b>			Refer urgently as Category 1
<b>EYE INFECTIONS/INFLAMATIONS</b>			
<b>Viral/bacterial Conjunctivitis with discharge</b>	<ul style="list-style-type: none"> <li>Reduced vision</li> <li>Discharge – purulent or watery</li> <li>Photophobia – with or without pain</li> <li>Itch/irritation</li> <li>Unilateral/bilateral</li> <li>Fluorescein staining (yes or no)</li> <li>Current topical therapy</li> <li>Contact lens wearer (type)</li> <li>Ocular pain</li> </ul>	<p>Appropriate broad spectrum topical antibiotic e.g. Chloramphenicol</p> <p>If unresponsive after four days, re-evaluate and refer if appropriate.</p> <p>Swab for Chlamydia /bacterium/viruses</p>	<p>Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM for:</p> <ul style="list-style-type: none"> <li>Red eye with reduced vision</li> <li>Suspected iritis</li> <li>Suspected corneal ulcer</li> <li>Suspected herpes simplex</li> <li>Herpes Zoster ophthalmicus with eye involvement</li> </ul>
<b>Dacryocystitis</b>			
<b>Acute</b>		One full course of broad spectrum systemic antibiotic e.g. Augmentin, Flucloxacillin and refer	Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM
<b>Chronic</b>	Referral to include prior treatment history and number of episodes		Refer to RBWH Eye Clinic

<b>Blepharitis</b>	Severe or persistent Ocular/lid changes	Eye lid cleaning (refer to useful links for patient education sheets)	Refer RBWH Eye Casualty
<b>Drug Allergy</b>		Cessation of drug, conservative treatment e.g. lubricants, topical decongestants, mast cell stabilisers and removal of allergies.	If unresponsive and severe refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM
<b>Vernal Catarrh</b>	Vernal catarrh is severe conjunctivitis often in younger age group. Characterised by <ul style="list-style-type: none"> <li>• Severe itch</li> <li>• stringy mucoid discharge</li> <li>• typical thickened swollen 'leathery' inferior fornix</li> <li>• +/- cobblestone papillae upper lid</li> </ul> Note: the discharge is quite characteristic		Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM
<b>Contact lens Wearer</b>	<ul style="list-style-type: none"> <li>• Discharge– purulent or watery</li> <li>• Photophobia – with or without pain</li> <li>• Itch/irritation</li> <li>• Unilateral/bilateral</li> <li>• Duration/frequency</li> <li>• Current topical therapy</li> <li>• Contact lens type– hard/soft</li> <li>• Acutely inflamed eyelid</li> <li>• Swelling of the lid and ecchymosis</li> </ul>	<ul style="list-style-type: none"> <li>• Avoid secondary topical drug therapy</li> <li>• Review contact lens management by patient</li> </ul>	If sub-acute, optometric management preferred.
<b>EYE LIDS/MALPOSITION</b>			
<b>Trichiasis</b>		Epilating – manual or otherwise	If unresponsive or recurrent refer category 3
<b>Ectropion Entropion</b>			Refer if symptomatic Category 2

<b>Thyroid Eye Disease</b>	Orbital History Symptoms	CT orbit CP (if possible) Thyroid Function Test (T3, T4, TSH, selective THS)	Refer if symptomatic Refer immediately if LOV, optic nerve involvement or corneal involvement
<b>Peri-orbital Cellulitis</b>			Urgent referral for adults Refer children immediately to RCH.
<b>Acute Chalazion or swellings</b>		<ul style="list-style-type: none"> <li>• Systemic AB e.g. Augmentin</li> <li>• +/- cyst drainage</li> </ul>	Chronic or recurrent Refer to RBWH Eye Casualty
<b>GLAUCOMA</b>			
<b>Family history</b>		Encourage all patients to have glaucoma screened by optometrist by age 45	If confirmed open angle glaucoma refer Category 3  Maintain ongoing review till appointment given. Re-refer if clinical condition deteriorates.
<b>Acute</b>	<ul style="list-style-type: none"> <li>• BCVA</li> <li>• Painful red eye</li> <li>• Los of vision (LOV)</li> <li>• Photophobia</li> <li>• Steamy cornea</li> <li>• Hard eye</li> </ul>		Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM
<b>Chronic</b>	<ul style="list-style-type: none"> <li>• Suspected chronic</li> <li>• Usually asymptomatic</li> </ul>	BCVA IOP Disc ratio History Field tests when possible	Suspicion of glaucoma – Optometrist evidence. Refer to department with accompanying clinical information e.g. fields, cup disc ratios, BCVA, IOP
<b>INTRA-OCULAR FOREIGN BODIES</b>			
	Site of entry X-ray/CT–when applicable History <ul style="list-style-type: none"> <li>• Visual Acuity–VA</li> <li>• Attendant ocular history signs</li> </ul>	Cover eye – non contact e.g. eye shield or adapted polystyrene cup or cone shaped X-ray film or cardboard	Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM

<b>LOSS OF VISION (LOV) –NON CATARACT</b>			
	<ul style="list-style-type: none"> <li>• Severe LOV</li> <li>• Speed of onset</li> <li>• Pain</li> <li>• Systemic disease</li> <li>• Afferent pupil defect (RAPD) present or not</li> <li>• Unilateral or bilateral</li> <li>• Fundus examination– often normal</li> <li>• Transient LOV – TIA's fundus exam bruit</li> </ul>	Dilate pupils to allow fundal examination only after exclusion of afferent pupil defect	Refer immediately if LOV < 1/12 Refer to RBWH if LOV > 1/12
<b>Arterial Occlusions</b>	Suspected giant cell arteritis	Immediate ESR	Refer immediately and contact RBWH Ophthalmology Registrar
<b>Retinal Detachments</b>	Evaluation Macular off or on Time since onset of symptoms	BCVA B scan when possible	Phone Ophthalmology registrar
<b>Flashers +/- floaters</b>	Evaluation History ophthalmological and medical		Phone Ophthalmology Registrar if sudden LOV <1/12 Refer to RBWH
<b>Macular Hole</b>	Acute symptoms <1 month Chronic symptoms > 1month		Acute – Refer immediately  Chronic – Refer cat: 2
<b>Epiretinal Membrane</b>	BCVA		Refer category 2
<b>Vitreous Haemorrhage</b>	Acute – sudden LOV Chronic LOV > 1 month		Refer immediately Refer Category 2
<b>Age Related Macular Degeneration</b>	BCVA Amsler Grid		Acute LOV refer immediately Refer Category 3
<b>Optic Neuritis</b>	Pain on lid movement LOV Loss of colour vision	1 <sup>st</sup> episode – MRI (brain and orbits) Visual Field Test	Refer immediately – phone ophthalmology registrar or send immediately to RBWH DEM
<b>Optic Nerve</b>	Unilateral or Bilateral		Refer immediately –

<b>Swelling or Pathology</b>	Papilloedema		phone ophthalmology registrar or send immediately to RBWH DEM
<b>OPHTHALMOLOGICAL HEADACHE</b>			
Tension	No neurological signs or symptoms Normal visual acuity – VA	No need for routine ophthalmic examination	Referrals not accepted
Vascular Migrainous cluster with visual symptoms	Normal vision  Suspect associate ocular pathology +/- loss of vision	No need for routine ophthalmic examination  CT, MRI	Refer RBWH Ophthalmology or Neurology Registrar
Raised Intracranial Pressure	+/- Neurological signs or symptoms		Refer immediately – phone ophthalmology or neurology registrar or send immediately to RBWH DEM.
Giant Cell Arteritis and other vascular diseases	Immediate ESR LOV	Immediate discussion with ophthalmology registrar for acute sight threatening giant cell arteritis is mandatory	Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM. Urgent referral if pathology is suspected with confirmatory signs/symptoms and raised ESR
Ocular Pathology	Headaches associated with ocular signs & symptoms: <ul style="list-style-type: none"> <li>• Red eye,</li> <li>• Epiphora,</li> <li>• Proptosis etc</li> </ul>		Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM Urgent referral if no loss of vision or not progressive loss of function.
Accommodative Aesthenopic	Confirmed absence of neurological, vascular, tension headaches etc.		For aesthenopic symptoms, suggest referral initially to optometrist for initial assessment

<b>ORBITAL PAIN</b>			
Proptosis	<ul style="list-style-type: none"> <li>• Acute, chronic, endocrine</li> <li>• Painful</li> <li>• Masses</li> <li>• Ocular movement</li> </ul>	CT	Acute proptosis – Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
<b>TRAUMA</b>			
Adnexal – lids	Functional anatomical integrity	Antibiotic ointment, pad	Refer as appropriate e.g. <ul style="list-style-type: none"> <li>• All full thickness lacerations of the upper lid</li> <li>• Suspected canalicular disruption</li> </ul> Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Orbit	Diplopia +/- X ray	AB as appropriate	
Penetrating non–magnetic metal or non metal, velocity		<b>NO NOSE BLOWING</b>	Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Chemical	<b>Irrigate immediately</b> <ul style="list-style-type: none"> <li>• acid, alkali, other always refer to manufactures information when possible</li> <li>• Phototoxic– burns</li> </ul>		Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Blunt	Hyphaema Traumatic mydriasis Loss of vision	<b>Sit upright of 30 minutes and assess hyphaema level</b>	Refer
External Foreign Bodies	Foreign bodies on ocular surface	Removal of solid practicals Topical AB	Always refer if in doubt

Corneal		Dark glasses Site specific within pupil zone If outside pupil zone, removal under LA	If difficult/complicated Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Sub-tarsal-Occult		Remove under LA Adjunctive fluorescein staining may help localisation	If difficult/complicated Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Keratitis	BCVA		Refer to RBWH Eye Casualty or phone Ophthalmology Registrar
<b>WATERY EYE</b>			
Acquired Adult – acute	See if fluorescein dye inserted in the eye can be blown from the nose after five minutes <ul style="list-style-type: none"> <li>• Photophobia/tiredness</li> <li>• Hazy and enlarged cornea</li> <li>• Frank suppuration</li> </ul>		Refer immediately if associate loss of vision – phone ophthalmology registrar or send immediately to RBWH DEM
Acquired Adult – chronic	Excessive lacrimation Inadequate drainage – Lid/punctual position History of trauma Nasal pathology		Refer category 2
<b>DRY EYE</b>			
	Non responsive to drug therapy  Bone marrow Transplant	Schimers Test Less than 6mm and/or not responding to drops	Refer category 1  Refer Category 2

<b>DRUG SCREENING</b>			
Plaquenil Screening	VA is less than 6/9 or, Ishihara less than 13/15 Patient has been on Plaquenil for at least 6/12		Refer category Maintain ongoing review until an appointment is given. Re-refer if clinical condition deteriorates.
Tamoxifen	Refer if VA > 6/12 and Ishihara less than 13/15		Refer category 2
<b>OCULAR MALIGNANCY</b>			
Suspected SCC/BCC Melanoma	History	Pathology results Photo/diagram	Refer Category 1
<b>SQUINT</b>			
<b>Congenital</b>	BCVA History, symptoms		Category 3
<b>Acute</b>			Refer Eye Registrar Category 1

**Abbreviations**

- BCVA – Best corrected visual acuity. Best visual corrected measurements are recorded with distance glasses on; if you are unable to complete this test please refer your patient to their optometrist for this measurement (non urgent cases only).
- VA – visual acuity
- LOV – Loss of vision
- Cat – Category
- OCT – Ocular Coherence Tomography
- CP – Computerised Perimetry
- IOP – intra ocular pressure
- DEM– Department of Emergency Medicine (RBWH)

**References**

The Wills Eye Manual, *'Office and Emergency Room Diagnosis and Treatment of Eye Disease'*, 4th Edition, Kunimoto, Derek. MD Kanitkar, Kundal. MD Makar, Mary. MD Friedberg, Mark. MD and Rapuano, Christopher. MD. Philadelphia 2004  
Ophthalmic Care, Marsden, Janet MSc BSc RGN OND, Manchester, 2006.  
QH Policy Framework for Specialist Outpatient Services, Brisbane, 2005.

**Useful Links**

- Royal Australian and New Zealand College of Ophthalmologists (RANZCO) < >
- Royal College of Ophthalmologists < >

Most major Eye Hospitals have internet sites containing information sheets for both professionals and patients.

- Sydney Eye and Ear Hospital <>
- Moorefield's Eye Hospital (UK) < >

Other useful sites

- Victoria Health < >
- Glaucoma Australia <>
- Low vision clinic/service <>
- Guide dogs for the Blind <>
- Blind Associations <>

## VISUAL ACUTIY

### *Visual acuity*

- Each eye is tested separately, ensuring the non tested eye is covered.
- Use the eye chart attached at three metres, the reading corresponds to the acuity listed on the chart.
- Recorded as VA R eye 6/ L eye 6/ with glasses or unaided (UA)
- Record the last complete line read by the patient
- If vision is less than 6/9
  - Test the patient with a pinhole (a piece of cardboard with a small hole will suffice)
  - Record as VA= PH R eye 6/ L eye 6/
- If the patient cannot see 6/60
- Record best vision as:
  - CF: count fingers – hold finger up at 40 cm and record if patient can count fingers
  - HM: hand movement – if the patient cannot count fingers, wave hand horizontally or vertically at 40 cm
  - PL: perception of light – if the patient cannot see hand movements, a bright light is shone form 30cm in each eye, ensuring the other eye is well covered and the room dark
  - NPL: No perception of light, the patient is unable to detect the light source

### ***RAPD: Relative Afferent Pupillary Defect (a.k.a. Marcus–Gunn Pupil)***

This refers to a discrepancy in the pupil light responses between the two eyes in the '*swinging light test*'.

- Shinning the torch in the normal eye causes constriction of both pupils then shinning it in the effected eye causes dilation in both pupils
- If so, there is said to be a RAPD in the abnormally responding eye. The response can be very subtle, if unsure record RAPD test completed unable to determine.
- A normal pupil light response would be equal constriction in both pupils as the torch is shone in each eye alternately.

**Royal Brisbane & Women's Hospital – Ophthalmology Referral**

Please fax to: 07 3636 5433

Or post to: New Case Coordinator

Eye Clinic, Level 8 Ned Hanlon Building RBWH

Butterfield St, Herston Q 4029

Title:  Mr  Mrs  MS  Other Surname:

Given Names:

DOB:

Address:

Phone Home:

Work:

Mobile:

Email:

Interpreter required: Yes

Language:

Medicare number:

Line number:

Expiry Date: –

Family contact number (if available)

Name:

Phone number:

GP or optometrist contact details:

Name:

Phone number:

Clinical reason for referral: *(severity, duration, physical findings)*

Relevant investigations results *(please attach even if NAD):*

Relevant past history: *(current medications, social history, ocular history)*

Complete the following eye assessment

Visual Acuity (BCVA)

Right

Left

Pupils

6/

6/

Round, equal & reactive to light

HM

HM

Pupil Abnormality

LP

LP

RAPD  Yes  No

NPL

NPL

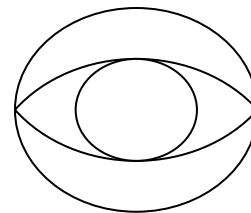
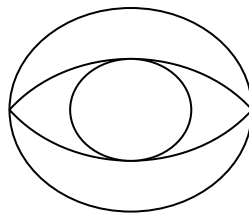
Eye Movement

Normal

Restricted– specify:

Diplopia – specify:

ILLUSTRATE AS APPROPRIATE



Right

Left

Refraction if available (mandatory for cataracts)

Right eye:

Left eye:

Practitioners Name or Stamp:

Address:

Phone:

Provider number:

Phone Inquires or urgent referrals can be directed to

Clinical Nurse Care Coordinator: 07 3636 7823

Urgent referrals or clinical inquires to Ophthalmology Registrar on call:

07 3636 8111