TRIAGING IN PRACTICE C-106831

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Learning Objectives

- Understand what constitutes a GOS eye examination
- Understand when patients are entitled to an early eye examination
- GOS or Not?
- Refining in-store triage protocols
- Deeper understanding of conditions that may result in patients coming in for an emergency appointment
- Understand the appropriate timescales in which patients should be assessed to prevent sight loss

General Ophthalmic Services Eye Exam

- Both the General Optical Council (GOC) and the National Health Service (NHS) refer to a sight test in accordance with the Opticians Act 1989. The Opticians Act outlines a set of requirements for the procedure, and this can only be carried out by a registered practitioner.
- The main requirements, as specified in the Opticians Act, are to:

1. Conduct an external examination
2. Conduct an internal examination
3. Conduct any additional examinations that are clinically necessary
4. Provide a written statement confirming:
    1. That the examinations above have been carried out
    2. Whether the patient is being referred and if so, the reasons for the referral
5. Provide a signed, written prescription for an optical appliance, or a signed written statement that no optical appliance is required.

- As such, 'sight test' is the legally defined phrase for the work that optometrists routinely do. In Scotland, under their General Ophthalmic Services (GOS) agreement, the NHS has chosen to use the term 'eye examination'.

https://www.aop.org.uk/our-voice/policy/the-term-sight-test

What recall would you apply?

What recall would you apply?	
60YO Male, T2 Diabetic, 6/6 OU, Under Diabetic Screening	
56YO Female, 6/7.5 OU, Under HES for Primary Open Angle Glaucoma	
77YO Male, 6/7.5 OU, Early Cataracts	
11YO Female, 6/6 OU, No Rx	
8YO Male 6/6 OU, -1.00D Myopic Shift since LEE	
44YO Female, No Rx, Family History of Glaucoma, 0.1 CD Ratio R&L, IOP 11mmHg R&L	

What recall would you apply?

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60YO Male, T2 Diabetic, 6/6 OU, Under Diabetic Screening	2 years
56YO Female, 6/7.5 OU, Under HES for Primary Open Angle Glaucoma	2 years
77YO Male, 6/7.5 OU, Early Cataracts	2 years
11YO Female, 6/6 OU, No Rx	2 years
8YO Male 6/6 OU, -1.00D Myopic Shift since LEE	6 months or 1 year
44YO Female, No Rx, Family History of Glaucoma, 0.1 CD Ratio R&L, IOP 11mmHg R&L	1 year or 2 year

When applying a recall, it is imperative that you exercise clinical judgement and do not apply blanket recalls. You should look at each patient on case-by-case basis and act in the best interest of the patient whilst following guidance.

Understanding Recalls

Minimum Sight Test Intervals		
Age	**Clinical Condition**	**Interval**
Under 16	All patients	1 year
16 – 59	All patients	2 years
60 – 69	All patients	2 years
70 & over	All patients	1 year
Any age	Diabetic (not in screening)	1 year
Any age	Glaucoma	2 years
40 & over	Glaucoma family history (not in monitoring scheme)	1 year
Any age 40 & over	Ocular hypertension (not in monitoring scheme)	1 year
Under 7	BV anomaly/corrected refractive error	6 months
7 – under 16	BV anomaly or rapidly progressing myopia	6 months

NHS England will look at how often patients are seen for routine sight test. Clause 37.4.1 of the GOS contract requires the contractor to 'satisfy itself that the testing of sight is necessary'.

Memorandum of Understanding clearly states that 'The GOS regulations require practitioners to satisfy themselves that a sight test is clinically necessary'.

Therefore, the intervals given are not to be read as applying automatically to all patients in a category. It is therefore not appropriate to automatically recall all patients who are under 16 or over 70 annually. This does not stop contractors seeing patients more frequently if there is a clinical need for a sight test. NHS England will challenge contractors who use blanket annual recalls.

Reference: https://www.abdo.org.uk/voucher-values/vouchers-at-a-glance-england-wales/
Reference: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/10/eye-health-may.pdf

Am I entitled to a GOS Eye exam?

Can I be seen early?	
75YO Female attends practice, LEE 10 months ago, patient reports struggling with reading glasses for past 2 months	
61YO Male attends practice, LEE 1 year ago, patient wants another eye exam before ordering new spectacles	
7YO Male attends practice with parent, LEE 10 months ago, patient has lost spectacles	
17YO Female attends practice, LEE 1 year ago, patient has lost spectacles	
63YO Male attends practice, LEE 1.5 years ago, patients RE has been red for past 2 days	
70YO Female attends practice, LEE 8 months ago, patient has been experiencing new floaters in LE for past 4 days	

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17YO Female attends practice, LEE 1 year ago, patient has lost spectacles	NO
63YO Male attends practice, LEE 1.5 years ago, patients RE has been red for past 2 days	NO
70YO Female attends practice, LEE 8 months ago, patient has been experiencing new floaters in LE for past 4 days	NO

Eligibility for GOS eye exam should be established before the examination takes place. It is a common misconception to state ‘you can have an early eye examination however if there is no change in prescription there may be a charge’.

Early Recall

England and Wales Early Recall Codes	
1	Patient is at risk of frequent changes of prescription for reasons not requiring medical referral or for reasons already known to a medical practitioner
2	Patient has pathology likely to worsen, for example age-related macular degeneration, cataract, corneal dystrophy or congenital anomalies.
3	Patient has presented with symptoms or concerns requiring ophthalmic investigation: **3.1** resulting in referral to a medical practitioner; **3.2** resulting in issue of a changed prescription; **3.3** resulting in either no change or no referral (the patient's record should indicate any symptoms shown to support this category of claim if necessary).
4	**4.1** Patient needing complex lenses **4.2** with corrected vision of less than 6/60 in one eye.
5	Patient has: **5.1** presented for a sight test at the request of a medical practitioner **5.2** is being managed by an optometrist under the GOC referral rules, for example suspect visual fields on one occasion which is not confirmed on repeat, or abnormal IOP with no other significant signs of glaucoma **5.3** identified in protocols as needing to be seen more frequently because of risk factors.
6	Other unusual circumstances requiring clinical investigation.

These are the codes available to optometrists for patients presenting before their recall.

We have a duty to only perform a sight test when it is clinically indicated. In the case of the NHS, the GOS contract regulations in England, Wales, and Northern Ireland require that the contractor 'satisfy itself that the testing of sight is necessary' in order to proceed with a GOS funded test. This means that there must be a potential refractive cause to a person's problems.

GOS is not the appropriate vehicle for patients who present with conditions (such as a red eye or flashes and floaters for example) or to 'check' VAs or IOPs where a 'sight test' is not necessary

Reference: https://www.college-optometrists.org/news/2019/january/end-in-sight-for-the-sight-test
Reference: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/10/eye-health-may.pdf

GOS or Not?

When patients present early you should consider why that patient is presenting early and if they're eligible for an early eye examinations.

We have a duty to only perform a sight test when it is clinically indicated. In the case of the NHS, the GOS contract regulations in England, Wales, and Northern Ireland require that the contractor 'satisfy itself that the testing of sight is necessary' in order to proceed with a GOS funded test. This means that there must be a potential refractive cause to a person's problems.

GOS is not the appropriate vehicle for patients who present with conditions (such as a red eye or flashes and floaters for example) or to 'check' VAs or IOPs where a 'sight test' is not necessary.

If we don't question or triage patients returning early, what risk does this pose to the patient?

Your next available appointment is in 2 weeks, and you simply book the patient in without any prior questioning. Have we acted in the patients best interest?

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Reference: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/10/eye-health-may.pdf

Triaging

Any patient calling into practice complaining of an eye/vision problem should be triaged.

Any patient presenting early, outside their recall should be questioned on whether they're having trouble with their eyes and then triaged appropriately.

Triaging allows us to establish the urgency in which a patient should be seen to ensure the patient receives the best level of care.

Schemes

In England many areas have either MECS (Minor Eye Condition Scheme) or CUES (Community Urgent Eyecare Scheme)

These services are offered by groups of local practices to ensure that urgent eyecare is available and accessible to all. Regardless of whether the patients' regular practice has availability or not.

In Wales there is WECS which is covers acute eye problems

In Scotland you have supplementary codes which cover patients presenting outside their normal eye exam interval.

MECS TRIAGE FORM

Date Received	Time Received	Received By:

Patient Details

Customer No.	First Name	Last Name	DOB
			/ /

Address	Mobile No.

GP Details

GP Surgery	CCG (Tick one)															
	Oxfordshire		Other													
Referral From:	GP		GP Reception		Pharmacist		NHS 111		Other Optom		Eye Casualty		Self Referral			

Reason for Referral (Presenting Symptoms)

Which Eye?	Right / Left / Both
When did it start?	
Are you a CL Wearer?	YES / NO

Additional Questions

Px presenting with: (Circle as appropriate)			Px presenting with: (Circle as appropriate)		
Red Eye **Painful Eye** **Sore / Irritated Eye** **Itchy Eye** **Eyelid Lump / Bump** **Foreign Body** **Trauma**	Is it Painful? Pain Score:	YES / NO / 10	**Reduced Vision** **Distorted Vision** **Visual Disturbance** **Double Vision** ***(Px will Require Dilation)***	Does it come and go or is it permanent?	Transient / Sustained
	Are you sensitive to Light?	YES / NO		Did it come on gradually or suddenly?	Gradual / Sudden
	Is there any change in Vision?	YES / NO		Any Pain? Pain Score	YES / NO / 10
	Have you had any recent eye surgery?	YES / NO When:		Any Headaches?	YES / NO

Px presenting with **Floaters / Flashes**: ***(Px will Require Dilation)***					
Do you have floaters in your vision?	YES / NO	Do you have any flashing lights in your vision?	YES / NO Right / Left / Both	Do you have a shadow, curtain, or veil in your vision?	YES / NO Right / Left / Both
If Yes, have you always had floaters?	YES / NO				
If Yes, do you have? (delete as appropriate)	NEW FLOATERS INCREASING FLOATERS STABLE FLOATERS	How long does the flashing in your vision last?		Do you have any reduction or change in vision	YES / NO

This section to be completed by Optometrist.

Outcome

URGENT MECS within 24 Hours		*ROUTINE MECS within 5 Days*		*Not suitable for MECS*	

Appointment Type

MECS SCHEME *No Charge*		*PRIVATE MECS (Anterior Eye)* *£25.00*		*PRIVATE MECS (Posterior Eye inc. OCT)* *£35.00*	

Pre-screening Required Prior to Appointment

Autos		*IOPs*		*Fundus Pics*		*OCT*		*Fields (specify test)*	

ACTION & ADVICE (Px unsuitable for MECS or unable to be seen within time frame)

Eye Casualty		*GP*		*Pharmacy*		*No Referral Necessary*	

Notes:

Optom Name:		*Optom Signature:*	

Appointment Confirmation

Date:	/ /	*Time:*		***Dilation Required? (Optom)***		*Dilation Px Told not to DRIVE*		*If PRIVATE MECS Advised of Charge*	

MECS TRIAGE FORM

Patient's Details

Patient ID:	
Title	
First Name:	
Last Name:	
DOB:	
Address:	
Mobile No.:	

Permission to go on Optomanager	
Uploaded onto Optomanager	

Received By:	
Time Received:	
Date Received:	

GP Practice

Abbey Road		Arnside		Ash Trees	
Askam		Atkinson		Bentham	
Bridgegate		Burnett		Captain French	
Cartmel		Central Lakes		Coastal Medical	
Dalton		Dalton Square		Duddon Valley	
Duke Street		Haverthwaite		James Cochrane	
King Street		Landscape		Liverpool House	
Lunesdale		Meadowside		Norwood	
Nutwood		Owen Road		Parkview	
Peninsula		Queen Square		Risedale	
Rosebank		Sedbergh		Station House	
Stoneleigh		Strawberry Garden		St.Marys	
The Family		Ulverston		Waterloo House	
Westgate Med		Windemere		Windsor	
Wraysdale		York Bridge		**OTHER (PRIVATE MECS)**	

*OTHER GP Details **(Private MECS)**:

Referral From:

GP / Receptionist		Self-Referral		NHS 111 / Hospital	
Pharmacy		Other Optom		Other	

Reason for Referral (presenting symptoms):

Which Eye?	Right / Left / Both
When did it Start?	
Are you a CL Wearer?	Yes / No

Eye Pain Eye Discomfort Sore / Irritated Eye Red Eye Dry Eye Watery Eye Eye Lumps / Bumps	**Q.1 – Is it Painful?**	→	YES	**See within 24 HOURS**
			NO	Go to Q.2
	Q.2 – Is there sensitivity to light?	→	YES	**See within 24 HOURS**
			NO	Go to Q.3
	Q.3 – Is there any change in vision?	→	YES	**See within 48 HOURS**
			NO	See within 14 Days (Check with Optom)
Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	→	YES	**See within 48 HOURS**
			NO	Go to Q.2
	Q.2 – If gradual, when did it start?	→	< 2 Months	See with 14 Days (Check with Optom)
			> 2 Months	See out of Pathway as Sight Test

Flashes and / or Floaters ***WILL REQUIRE DILATION***	**Q.1 – What are your symptoms?**	Floaters / Flashes / Both	**Q.4 – When did your symptoms start, change or worsen?**	**< 6 Weeks**	**See within 24 HOURS**
	Q.2 – If just floaters, have you always had floaters?	YES (Move to Q.3)		6 Weeks to 2 Months Stable Symptoms	See within 14 Days (Check with Optom First)
		NO (Move to Q.4)		**6 Weeks to 2 Months Increasing Symptoms**	**See within 24 HOURS**
	Q.3 – If patient has always had floaters, are they?	Stable / New Floaters / Increase		>2 Months	Likely to exit pathway (Check with Optom First)

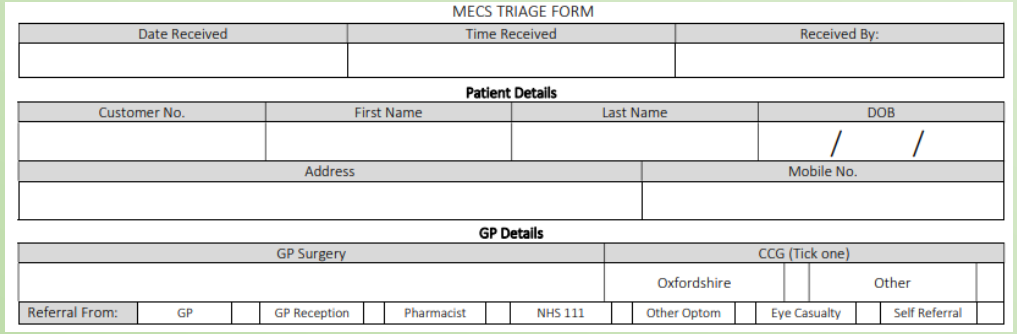
Advice Given	You should advise the patient to contact you at any time if symptoms become worse, or if out of hours, then contact GP or NHS 111 for further guidance. If no other advice is available then the patient should know to go to a hospital A & E Eye Department, or to seek medical advice in any event if they are generally unwell.
Action Taken if unable to see patient	

Appointment Date		Appointment Time	

Appointment Checklist

Patient advised DO NOT TO DRIVE: ***Mandatory for ALL DILATIONS***	**YES / NO**
Patient Requiring DILATION told to arrive 35 mins before: ➢ **FLASHES AND FLOATER** ➢ **REDUCED/DISTORTED VISION**	**YES / NO**
Is patient able to climb stairs? (Step Free Access) ➢ If **NO** - see Optom **BEFORE** booking appointment ➢ Offer these patients KMB as first choice	YES / NO
If PRIVATE MECS, Told £25 Charge	YES / NO

How to Triage (Patient Information)



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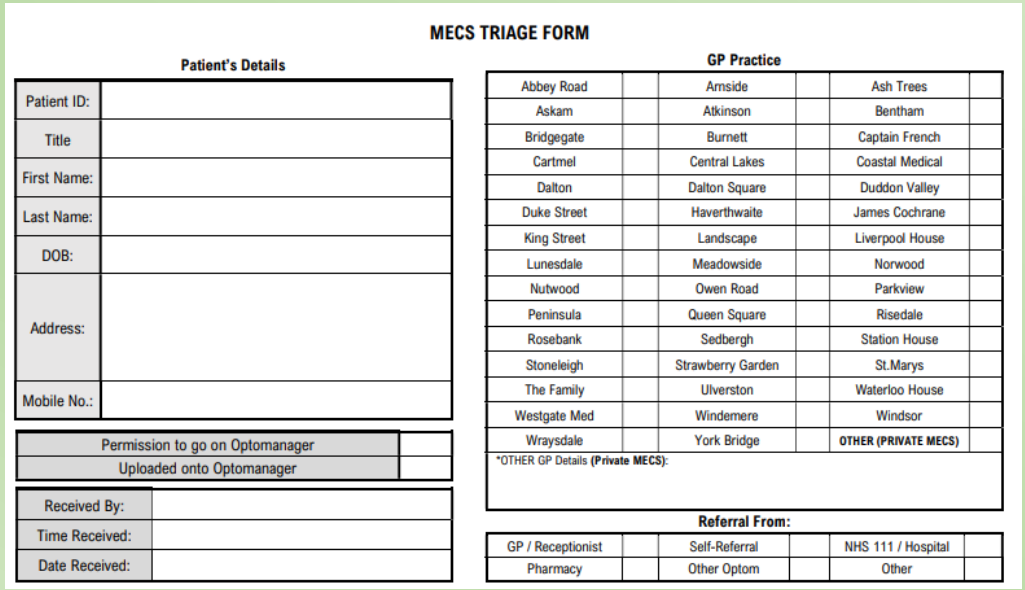

MECS TRIAGE FORM

Patient's Details

Patient ID:	
Title	
First Name:	
Last Name:	
DOB:	
Address:	
Mobile No.:	

Permission to go on Optomanager	
Uploaded onto Optomanager	

Received By:	
Time Received:	
Date Received:	

GP Practice

Abbey Road		Arnside		Ash Trees	
Askam		Atkinson		Bentham	
Bridgegate		Burnett		Captain French	
Cartmel		Central Lakes		Coastal Medical	
Dalton		Dalton Square		Duddon Valley	
Duke Street		Haverthwaite		James Cochrane	
King Street		Landscape		Liverpool House	
Lunesdale		Meadowside		Norwood	
Nutwood		Owen Road		Parkview	
Peninsula		Queen Square		Risedale	
Rosebank		Sedbergh		Station House	
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The Family		Ulverston		Waterloo House	
Westgate Med		Windemere		Windsor	
Wraysdale		York Bridge		**OTHER (PRIVATE MECS)**	

*OTHER GP Details **(Private MECS)**:

Referral From:

GP / Receptionist		Self-Referral		NHS 111 / Hospital	
Pharmacy		Other Optom		Other	

It may seem easy to copy patient information directly from PMS, however you should always ensure you record the patients most up to date information and most importantly ***BEST CONTACT NUMBER.***

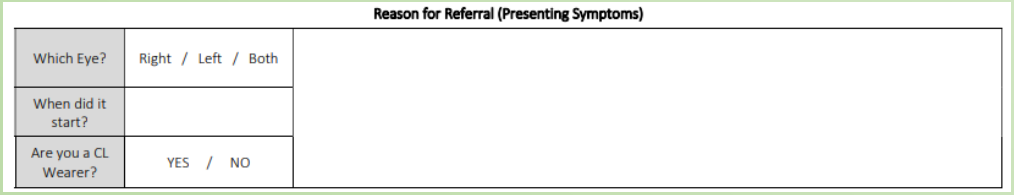
Often with triaging we have to call the patient back following a conversation with an optometrist and there is nothing more frustrating than copying an out-of-date number or landline directly from a patient record.

GP details are important as schemes usually require patients to be registered with a local GP to access funded services. Patients from outside the area can still be seen privately.

It is important to record the name of the person completing the triage form and the time the form was completed, as many schemes require patients to be triaged and contacted in an allotted timeframe. This allows you to monitor compliance and ensure team members are triaging correctly.

How to Triage (Primary Complaint)

Before asking any specific questions to elicit the information we require, you should ask the patient openly what problems they're experiencing. This allows the patient to explain in their own words what's wrong with their eyes. It is important to copy like for like what the patient mentions to you in this section.



Reason for Referral (Presenting Symptoms)

Which Eye?	Right / Left / Both	
When did it start?		
Are you a CL Wearer?	YES / NO	

It is important to establish which eye (or both) is troubling the patient.

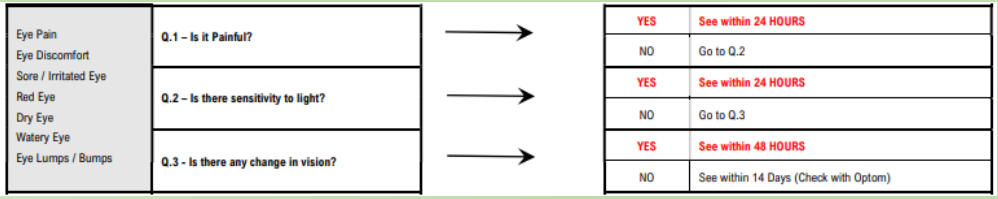
Onset is important in helping determine urgency. Some schemes also have cut off periods in what is determined acute and therefore funded (e.g. 6 weeks).

CL wearers in the first instance should see their provider for eyecare related to CL wear before accessing funded service. In any instance, it is important to establish if a patient is a CL wearer as the urgency in which they need to be seen is different to that of a non-CL wearer particularly in relation to infections.

How to Triage (Part 1)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

Px presenting with: (Circle as appropriate)		
Red Eye **Painful Eye** **Sore / Irritated Eye** **Itchy Eye** **Eyelid Lump / Bump** **Foreign Body** **Trauma**	Is it Painful? Pain Score:	YES / NO / 10
	Are you sensitive to Light?	YES / NO
	Is there any change in Vision?	YES / NO
	Have you had any recent eye surgery?	YES / NO When:



Pain scoring is the 1st key piece of information. Not only to help determine urgency but also begin running a differential of what you might be dealing with.

Generally, a pain score <4 is treated as routine.

A pain score of 5 and above is treated as urgent

It is important to establish if a patient is describing discomfort/irritation or pain.

Using examples can help establish the level of pain being experienced, i.e:

“On a scale of 1-10, 1 being you want to rub the eye occasionally and 10 being unbearable pain, how painful is your eye?”

How to Triage (Part 1)

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	Are you sensitive to Light?	YES / NO
	Is there any change in Vision?	YES / NO
	Have you had any recent eye surgery?	YES / NO When:

Light sensitivity (Photophobia) is indicative of a more serious problem with the eyes.

Light sensitivity is a sign that the cornea is involved and is commonly experienced by patients with abrasions, ulcers, uveitis, severe dry eye/erosion.

Eye Pain Eye Discomfort Sore / Irritated Eye Red Eye Dry Eye Watery Eye Eye Lumps / Bumps	**Q.1 – Is it Painful?**	→	YES: See within 24 HOURS NO: Go to Q.2
	Q.2 – Is there sensitivity to light?	→	YES: See within 24 HOURS NO: Go to Q.3
	Q.3 - Is there any change in vision?	→	YES: See within 48 HOURS NO: See within 14 Days (Check with Optom)

How to Triage (Part 1)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

Px presenting with: (Circle as appropriate)		
Red Eye **Painful Eye** **Sore / Irritated Eye** **Itchy Eye** **Eyelid Lump / Bump** **Foreign Body** **Trauma**	Is it Painful? Pain Score:	YES / NO / 10
	Are you sensitive to Light?	YES / NO
	Is there any change in Vision?	YES / NO
	Have you had any recent eye surgery?	YES / NO When:

A change in vision indicates a patient needs to be assessed more urgently because, again the cornea could be involved.

While a change in vision can indicate something serious or sight threatening, it isn't uncommon for patients with dry eyes to complain of unstable/variable vision, or patients with infections complaining due to discharge build up in eye.

Eye Pain Eye Discomfort Sore / Irritated Eye Red Eye Dry Eye Watery Eye Eye Lumps / Bumps	**Q.1 – Is it Painful?**	YES	See within 24 HOURS
		NO	Go to Q.2
	Q.2 – Is there sensitivity to light?	YES	See within 24 HOURS
		NO	Go to Q.3
	Q.3 - Is there any change in vision?	YES	See within 48 HOURS
		NO	See within 14 Days (Check with Optom)

But generally, any patient who mentions a change in vision should be assessed within 24 hours

How to Triage (Part 1)

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Px presenting with: (Circle as appropriate)		
Red Eye **Painful Eye** **Sore / Irritated Eye** **Itchy Eye** **Eyelid Lump / Bump** **Foreign Body** **Trauma**	Is it Painful? Pain Score:	YES / NO / 10
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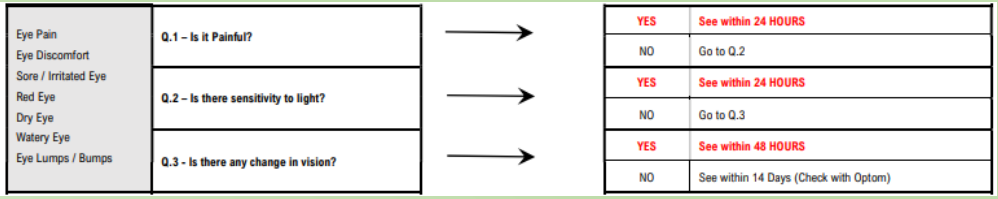
	Have you had any recent eye surgery?	YES / NO When:

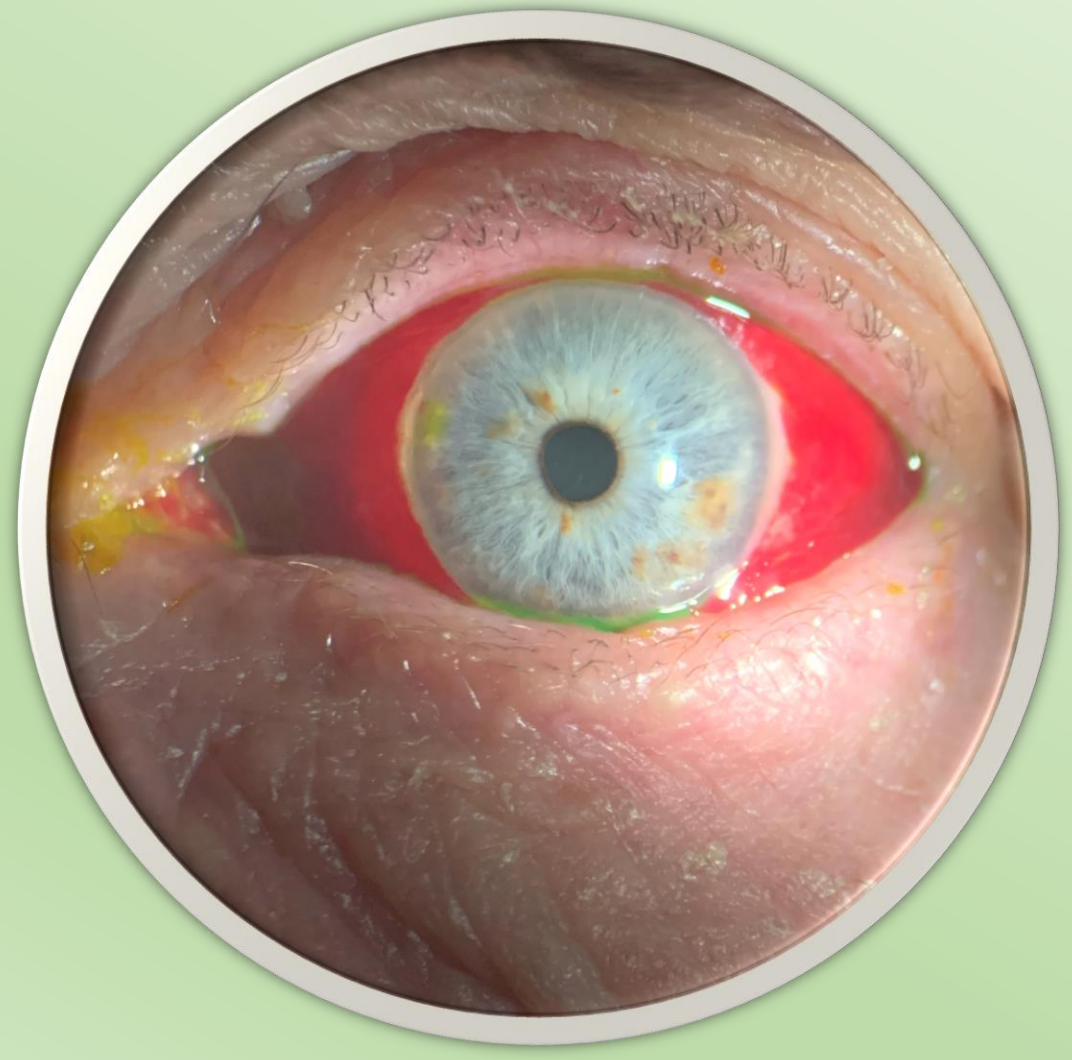


From a scheme point of view patients who have had surgery in the last 30 days remain the responsibility of the provider who performed the surgery and should contact them.

The most common patients to encounter in this scenario would be patients following cataract surgery.

Common post op complications to encounter are dry eye, corneal oedema, uveitis, CMO and more seriously in rare cases retinal detachment or endophthalmitis.

Red Eye: Subconjunctival Haemorrhage



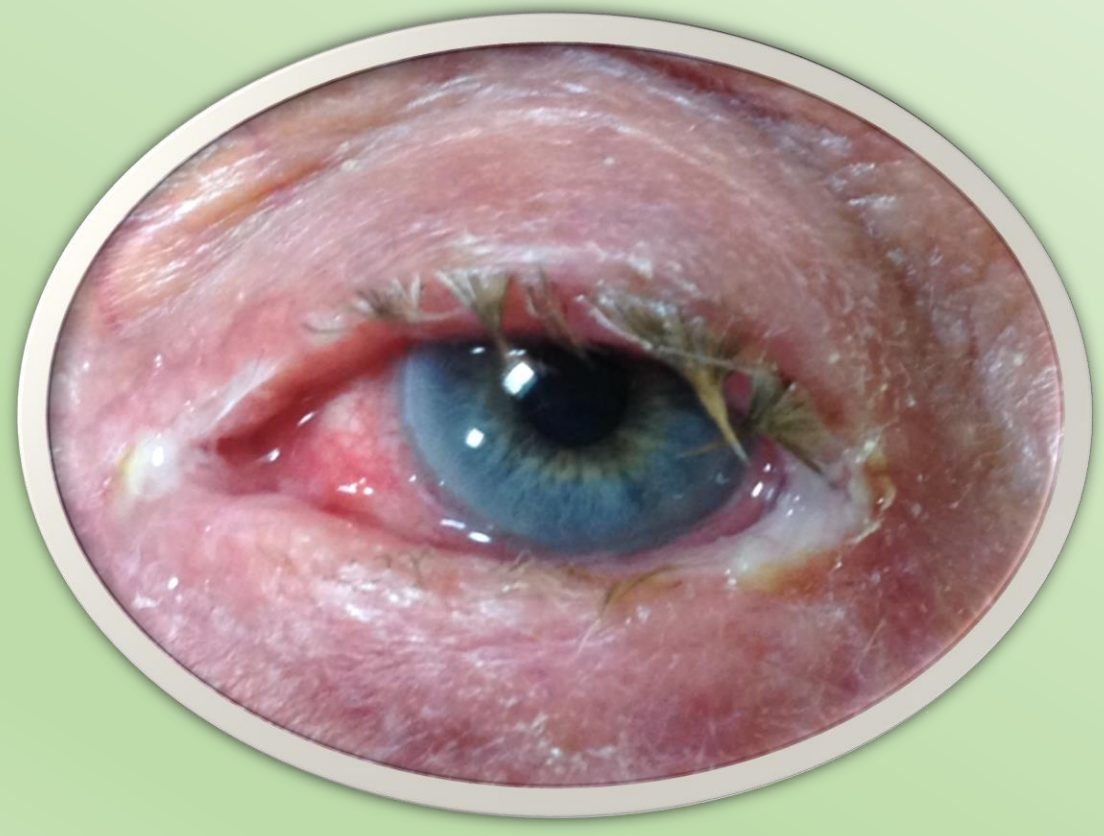
Px typically presents with the following:

- Bloodshot eye
- Slight discomfort but otherwise no other symptoms

How the patient might be managed:

- Lubricants for discomfort but will usually resolve within 2 weeks.
- Recurrent episode can be referred to GP for blood tests.

Red Eye: Bacterial Conjunctivitis



Reference: https://www.ophthalmologytraining.com

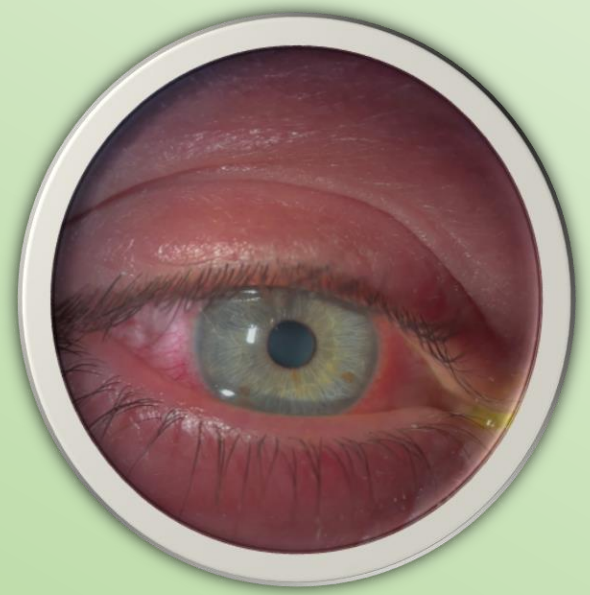
Px typically presents with the following:

- Unilateral/Bilateral Red Eye
- Mucus discharge common, complaint of eyes being stuck together on waking
- Sore/irritated eyes

How the patient might be managed:

- Hygiene to prevent spread to fellow eye or others
- Chloramphenicol but symptoms typically resolve in 7 days with or without antibiotics
- Persistent cases may require referral to HES

Red Eye: Viral Conjunctivitis



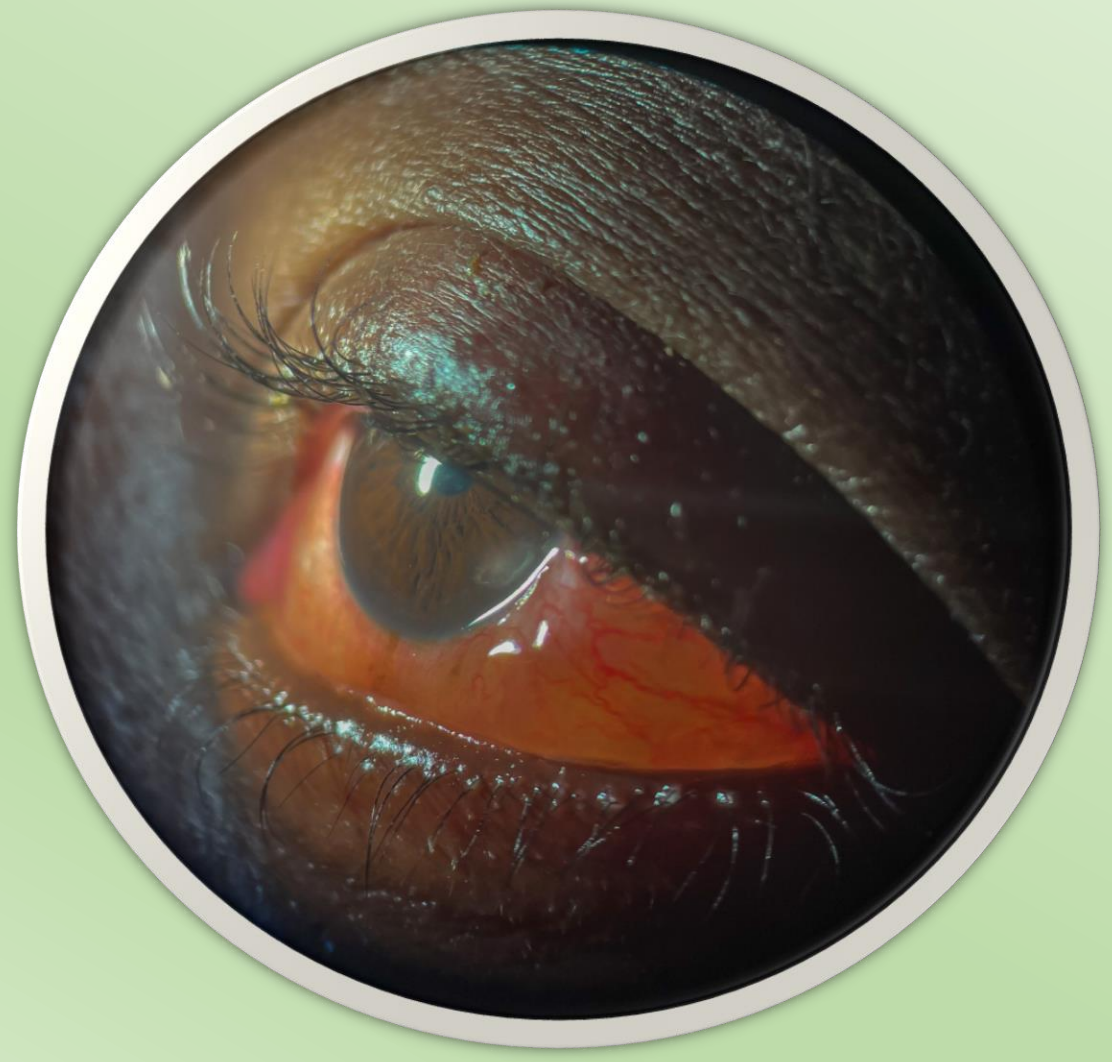
Px typically presents with the following:

- Unilateral/Bilateral Red Eye
- Watery Discharge
- Photophobia (indicates corneal involvement)
- Soreness/Irritation
- Current or Recent Cold
- Red eye which hasn’t improved with Chloramphenicol

How the patient might be managed:

- Self-limiting, symptoms typically resolve in 7 days
- Hygiene to prevent spread
- Referral if there is corneal involvement

Red Eye: Allergic Conjunctivitis



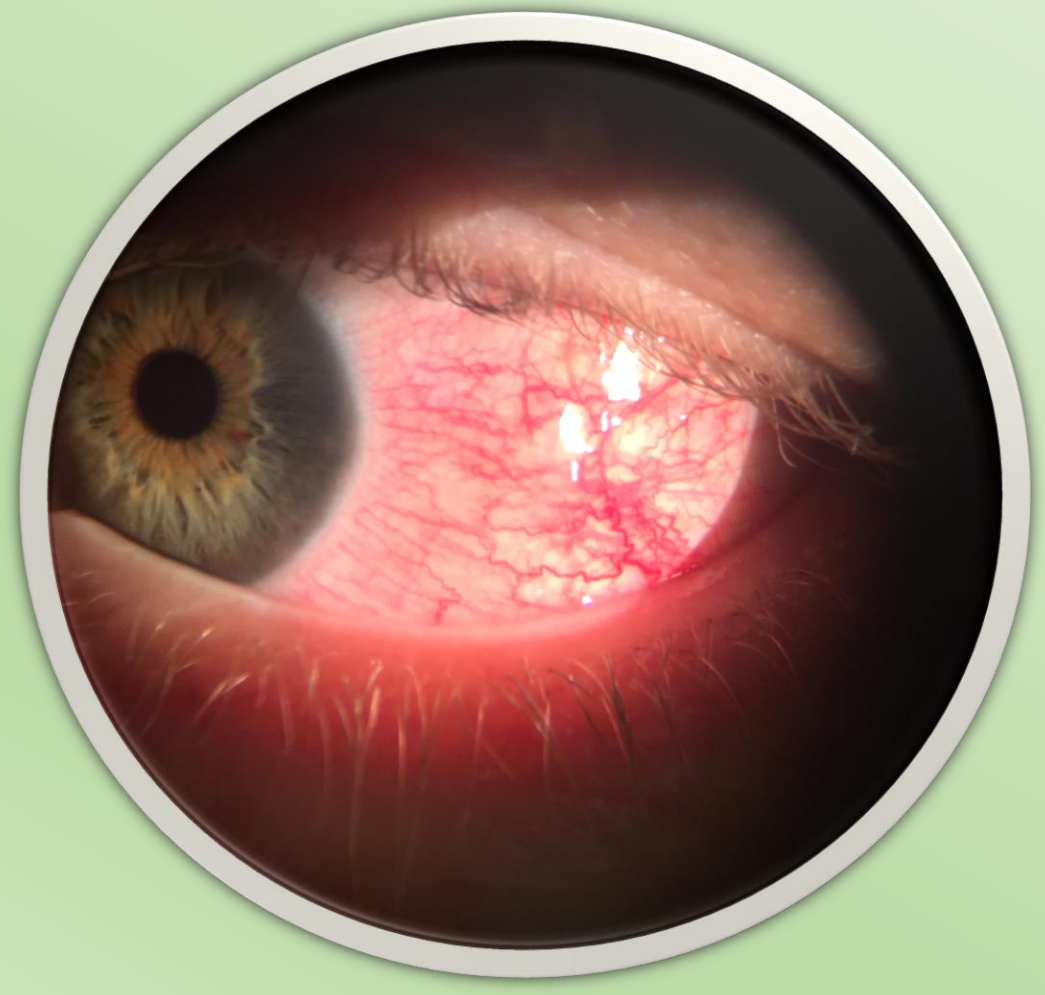
Px typically presents with the following:

- Unilateral/bilateral red eye
- Sore/itchy sensation
- Watery discharge
- Swollen lids and conjunctiva
- Pre-existing seasonal (grass, tree etc.) or perennial (dust, dander etc.)
- Acute exposure to allergen

How the patient might be managed:

- Cold compress
- Mast cell stabilisers (Opticrom)
- Topical Antihistamines
- Oral Antihistamines

Red Eye: Episcleritis



Px typically presents with the following:

-Diffuse or localised redness

-Mostly unilateral

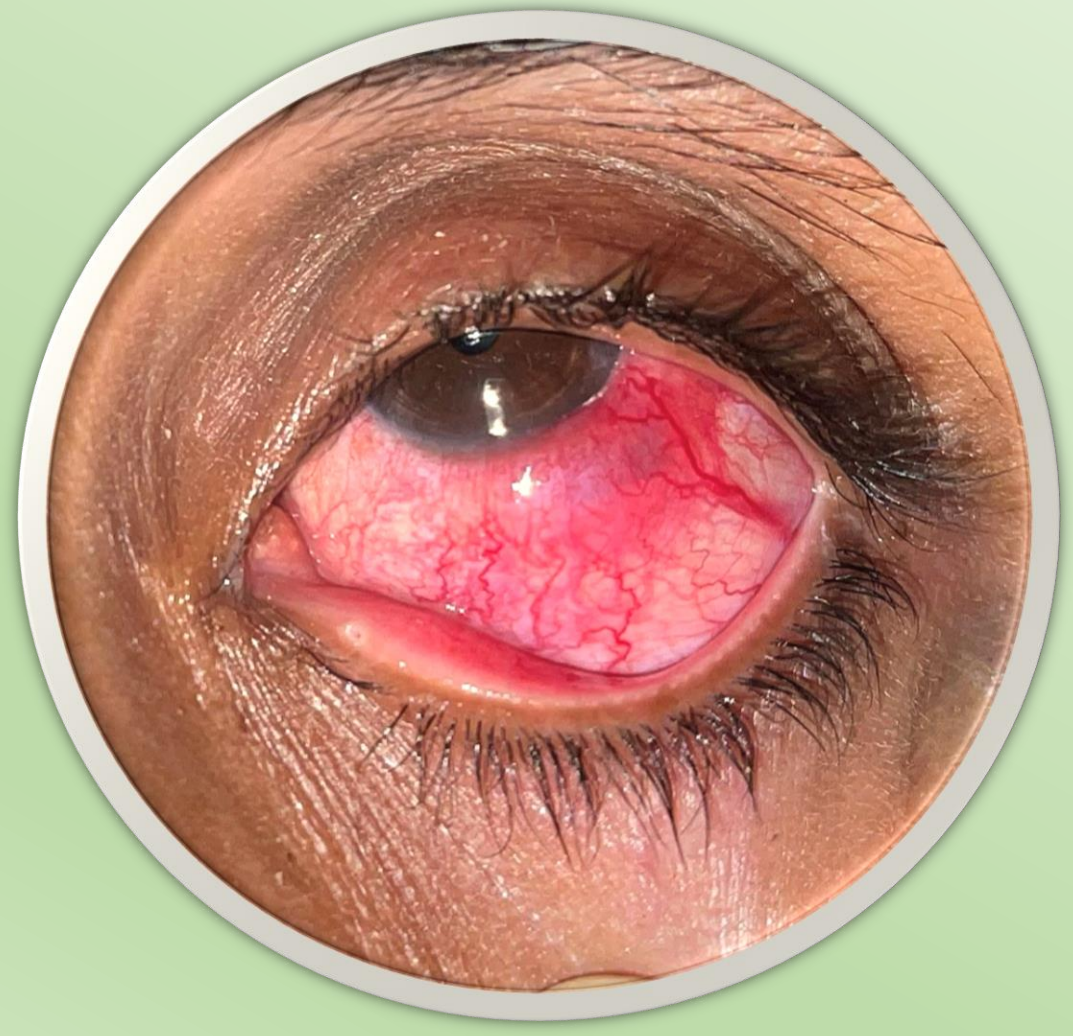
-Mostly painless, some patients may report discomfort and some tenderness

How the patient might be managed:

-Most cases are self-limiting

-Persistent or painful cases may be referred for topical anti-inflammatories.

Red Eye: Scleritis



Reference: Dr Neha Vyas Joshi @cornea_tales

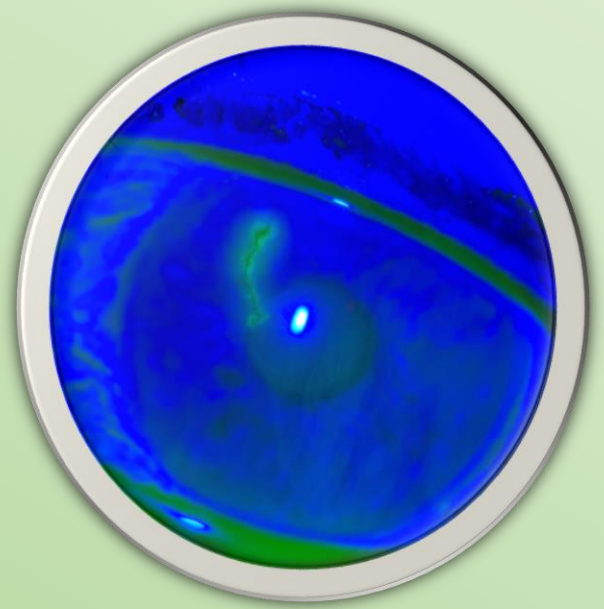
Px typically presents with the following:

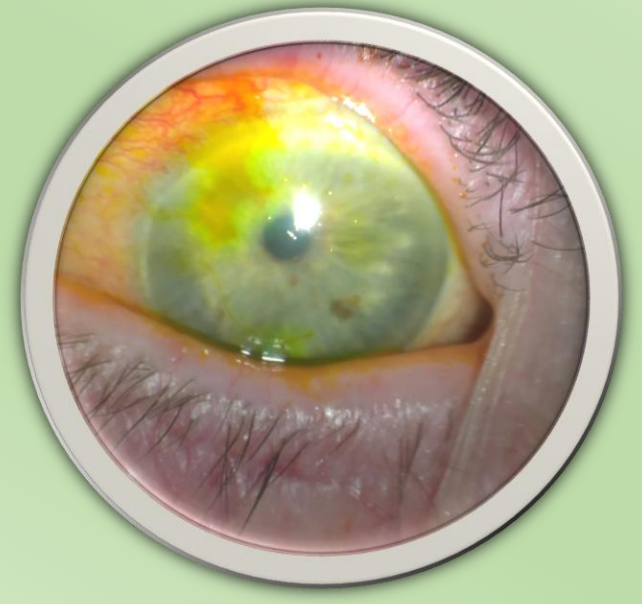
- Often described as the toothache of the eye
- Severe ocular pain
- Tenderness of the globe
- Deep dark red/purple injection
- Associated with autoimmune diseases (e.g. rheumatoid arthritis)

How the patient might be managed:

- URGENT referral to HES for diagnosis and treatment

Red Eye: Herpes Simplex Keratitis





Px typically presents with the following:

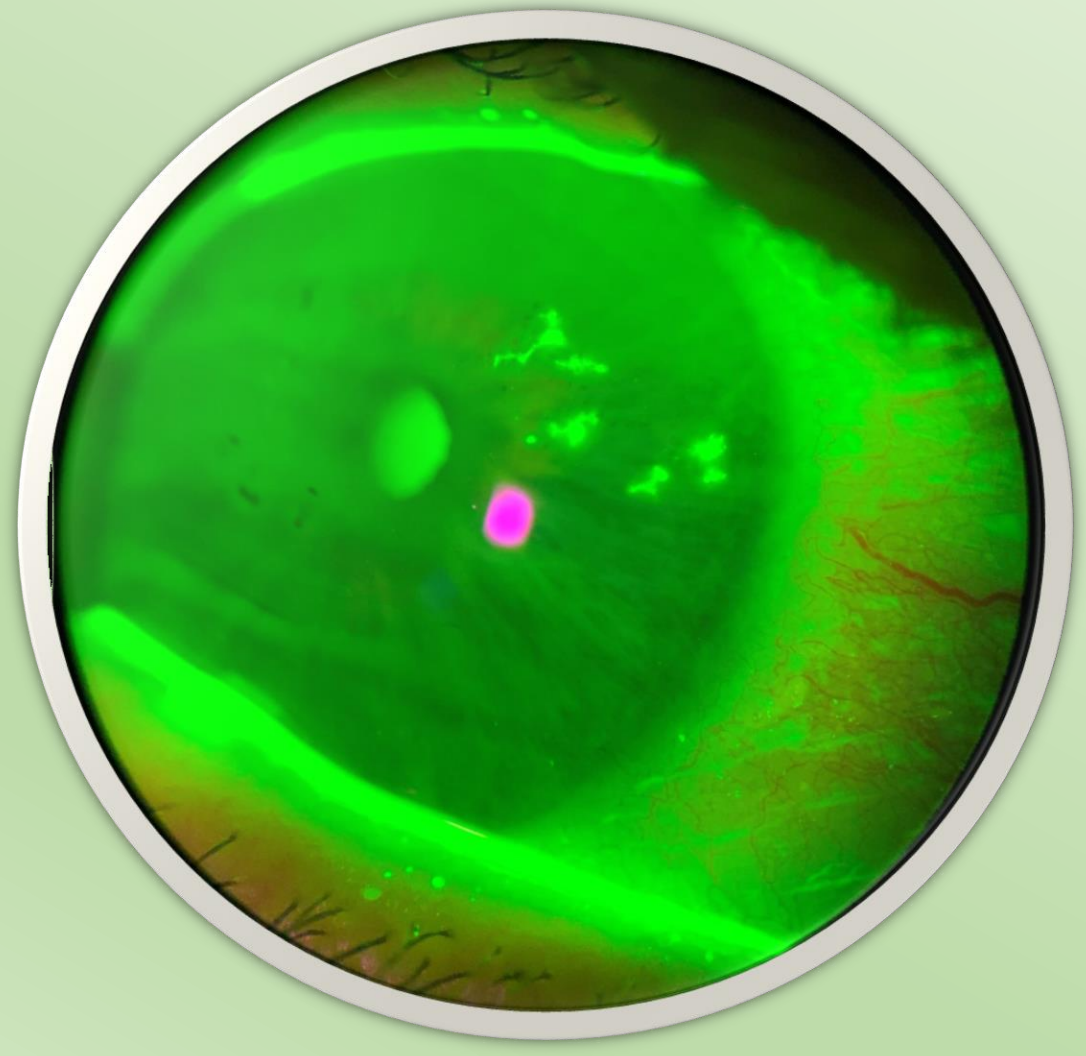
- Severe ocular pain
- Redness
- Photophobia
- Reduced vision
- History of HS infections
- Immune compromised

How the patient might be managed:

-URGENT Referral to HES

- Px is usually managed with topical anti-inflammatory and anti-viral

Red Eye: Herpes Zoster Ophthalmicus



Px typically presents with the following:

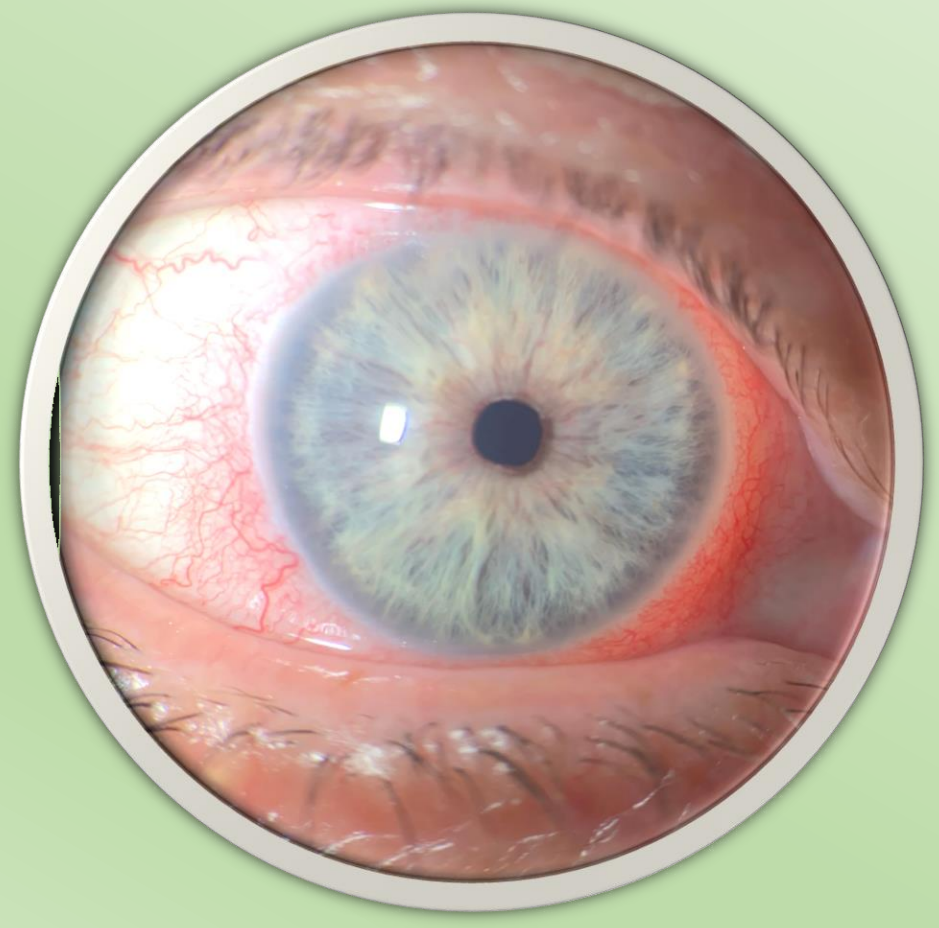
- Eye pain
- Redness
- Skin rash on affected side of face
- Reduced vision

How the patient might be managed:

-URGENT Referral to HES

- Px usually managed with topical and oral anti-viral

Red Eye: Acute Anterior Uveitis



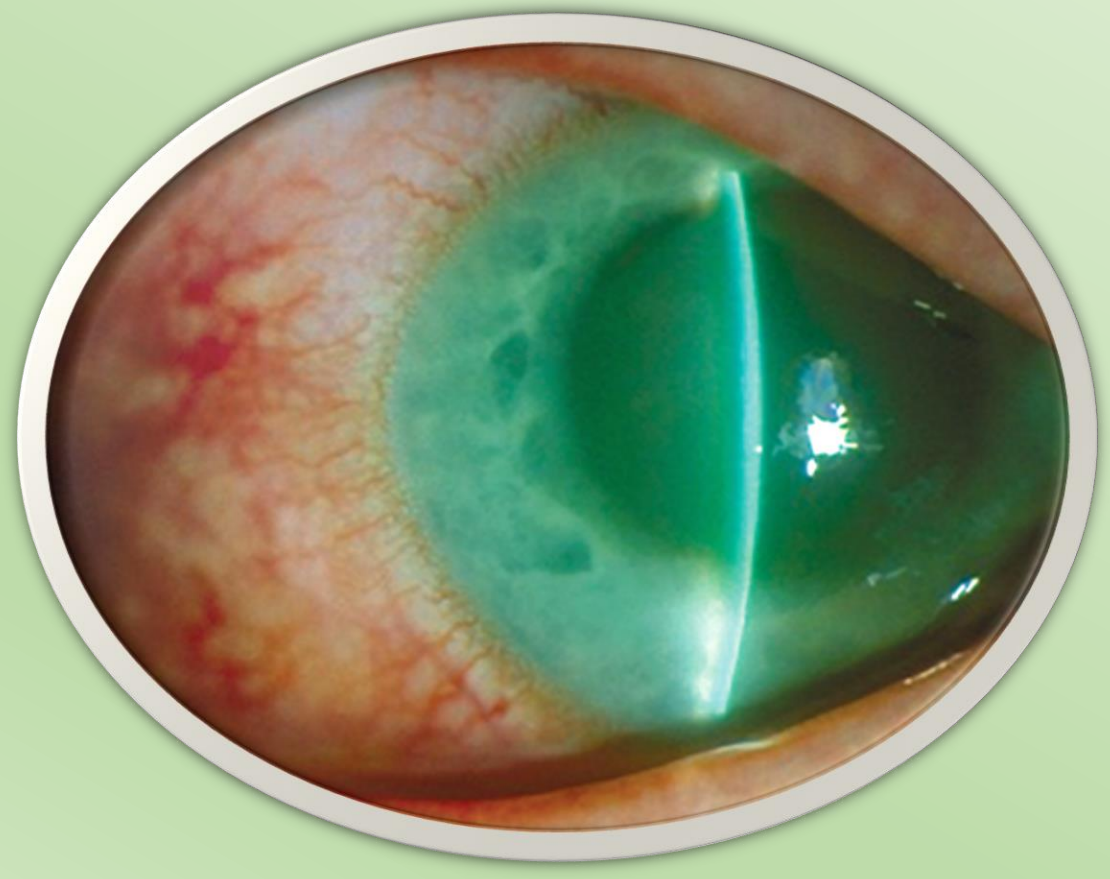
Px typically presents with the following:

- Eye pain
- Photophobia
- Reduced vision
- Characteristic halo of redness around iris

How the patient might be managed:

- URGENT Referral to HES
- Px usually managed with topical anti-inflammatory and IOP lowering drops.

Red Eye: Acute Angle Closure



Px typically presents with the following:

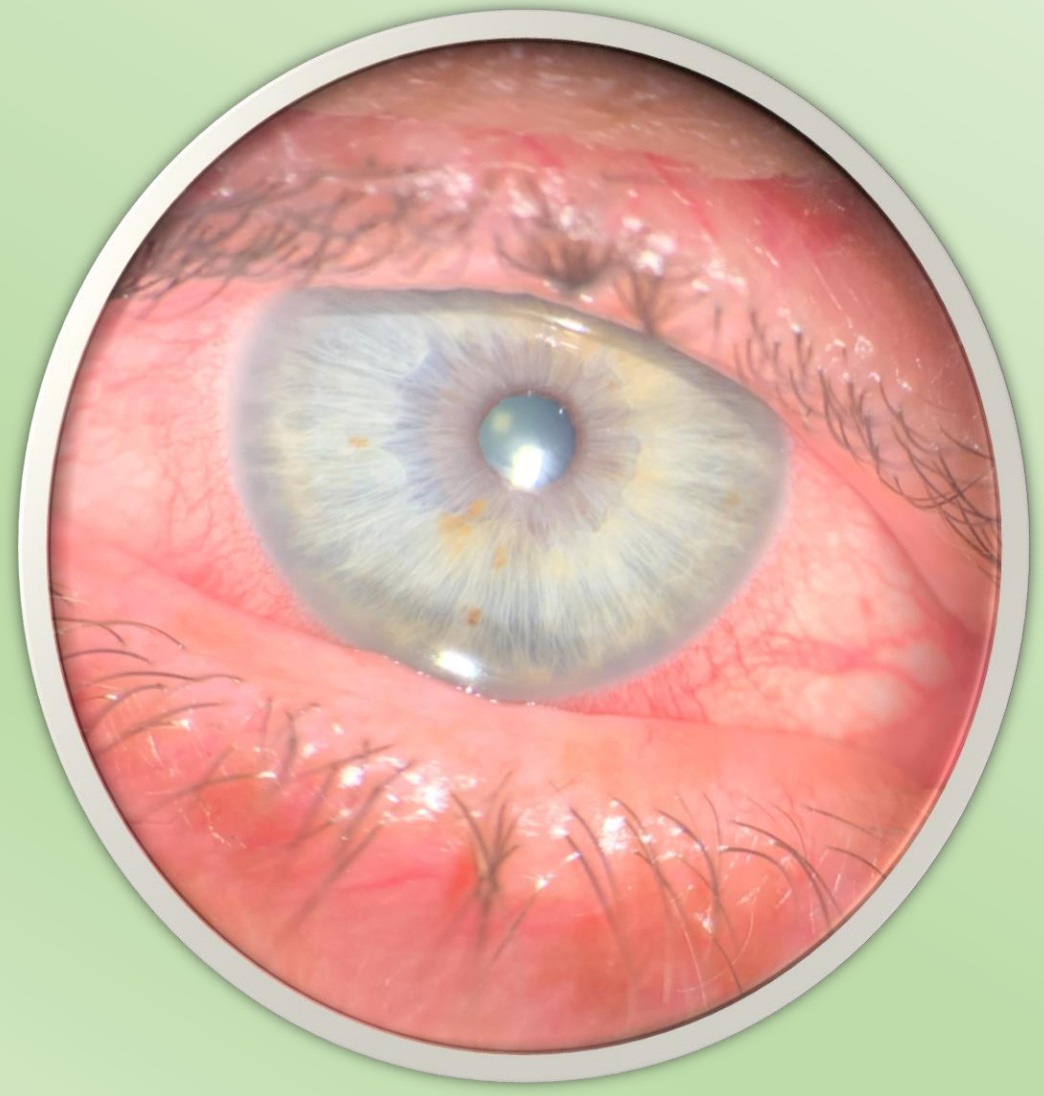
- Severe ocular pain
- Nausea
- Loss of vision
- Redness
- Haloes around lights

How the patient might be managed:

- EMERGENCY referral to HES

Reference: American Academy of Ophthalmology aao.org

CL Associated Red Eye: CL Acute Red Eye



Px typically presents with the following:

- Sudden onset
- Following sleeping in CL
- Watery Discharge
- Redness
- Photophobia
- Irritation
- May notice white dots on cornea

How the patient might be managed:

- Cease CL wear, will need refit if extended wear as chance of recurrence is high
- Self-limiting
- Lubricants for irritation

CL Associated Red Eye: CL Peripheral Ulcer

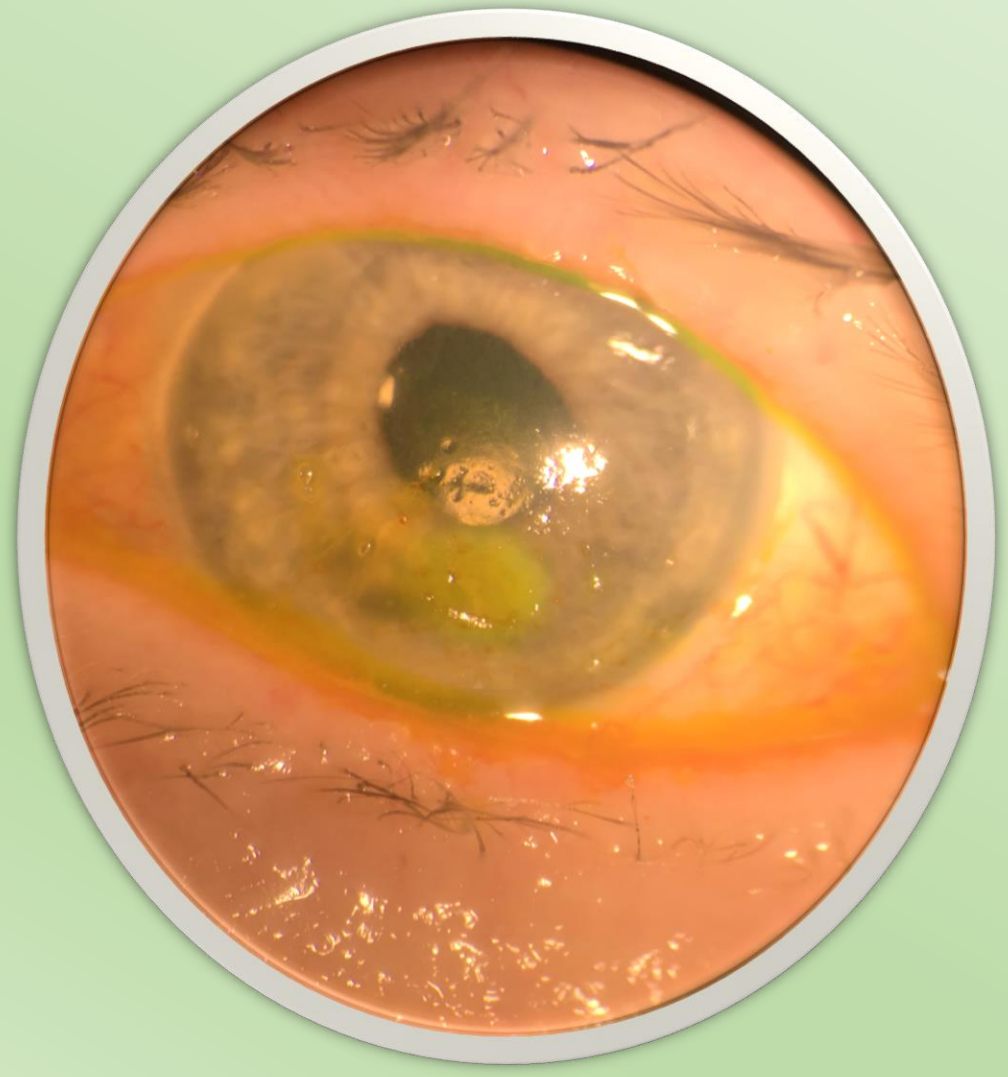
Px typically presents with the following:

- Px may be completely asymptomatic
- Red eye
- Photophobia
- FB sensation
- SX's improve with lens removal

How this patient might be managed:

- Cease contact lens wear
- Monitor for sign of infective keratitis
- Lubricants for irritation
- Prophylactic antibiotics
- HES referral for persistent cases

CL Associated Red Eye: Microbial Keratitis



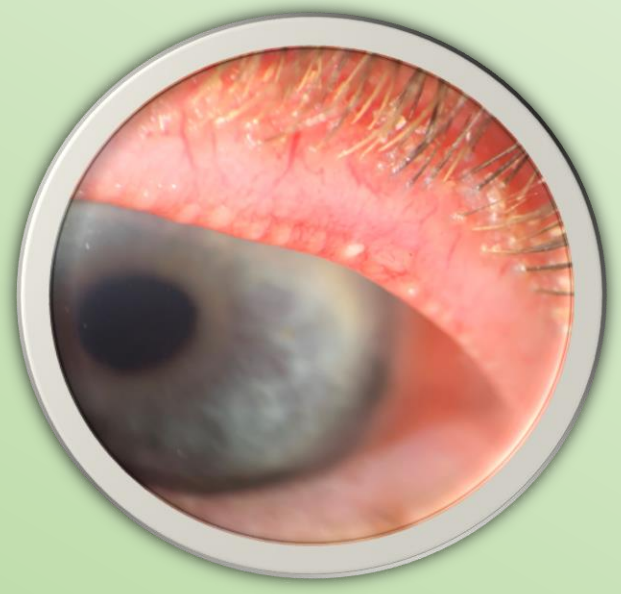
Px typically presents with the following:

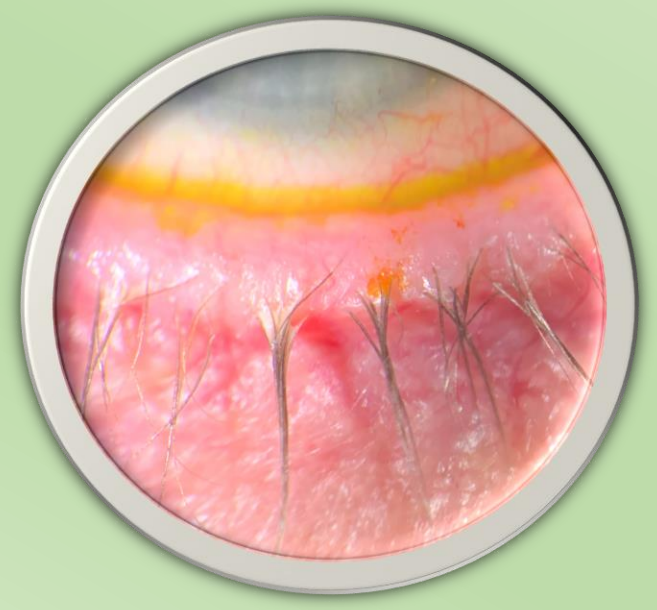
- Severe eye pain typically worsening on lens removed
- Reduced vision
- Severe photophobia
- Mucus Discharge

How might the patient be managed:

- Emergency Same Day Referral to HES
- Acanthamoeba needs to be ruled out in CL wearer as a matter of urgency

Sore/Irritated/Itchy Eye: Blepharitis/Demodex





Px typically presents with the following:

- One of the most common conditions to encounter in practice
- Itchy/sore/irritated eyelids
- Rubbing eyes
- Crusting on lashes in the morning
- Eye streaming when outside
- Recurrent visits for similar issues

How patients might be managed:

- Chronic issue
- Long term lid hygiene (hot compress + lid scrubs)
- In practice treatment (BlephEx, Zocushield, NuLids)
- Direct patient to try self-care in the first instance

Sore/Irritated/Itchy Eye: Dry Eye

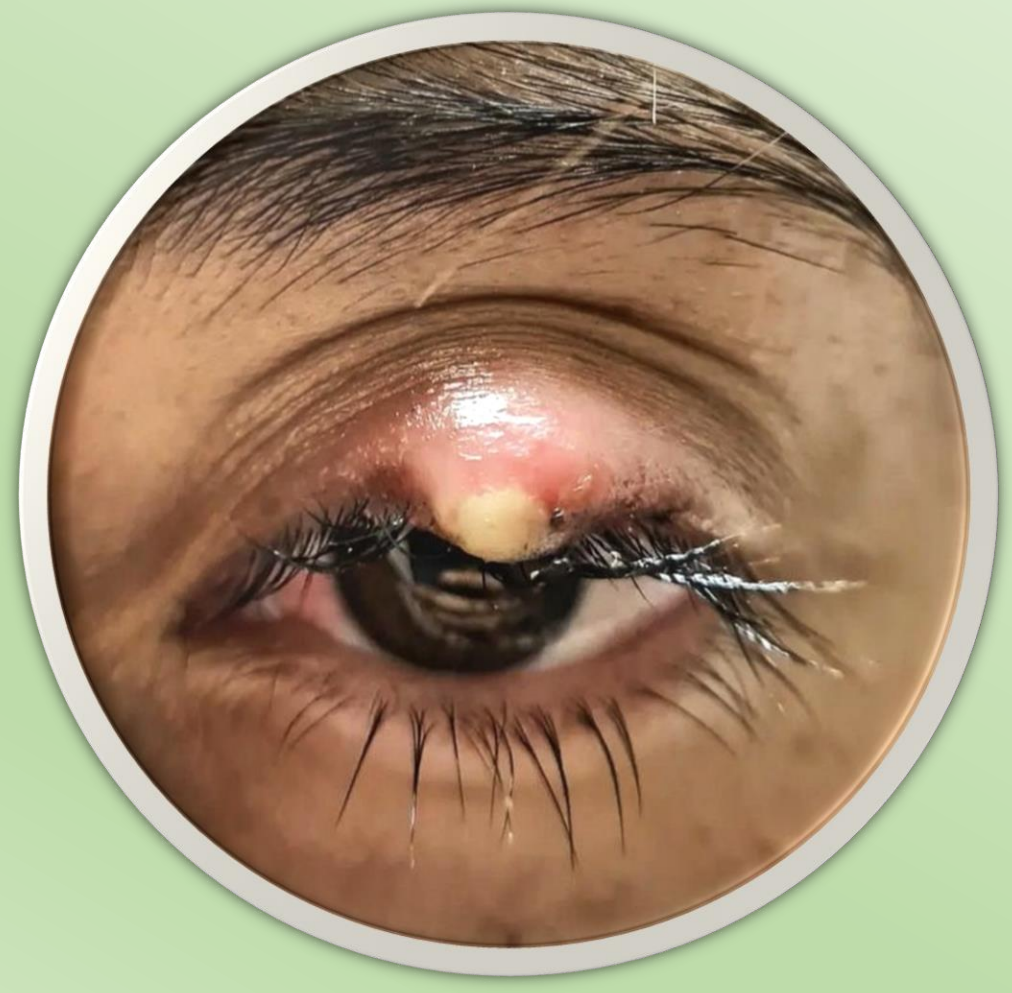
Px typically presents with the following:

- One of the most common conditions to encounter in practice
- Often goes hand in hand with blepharitis
- Sore/irritated eyes
- Burning/gritty
- Variable vision (blink to clear vision)
- Excessive tearing

How the patient might be managed:

- Chronic Issue
- Artificial tears in conjunction with lid hygiene
- Aqueous or lipid-based drops depending on type of dry eye
- Newer treatment such as IPL

Lid Lump/Bumps: Chalazion



Reference: @optometry.case

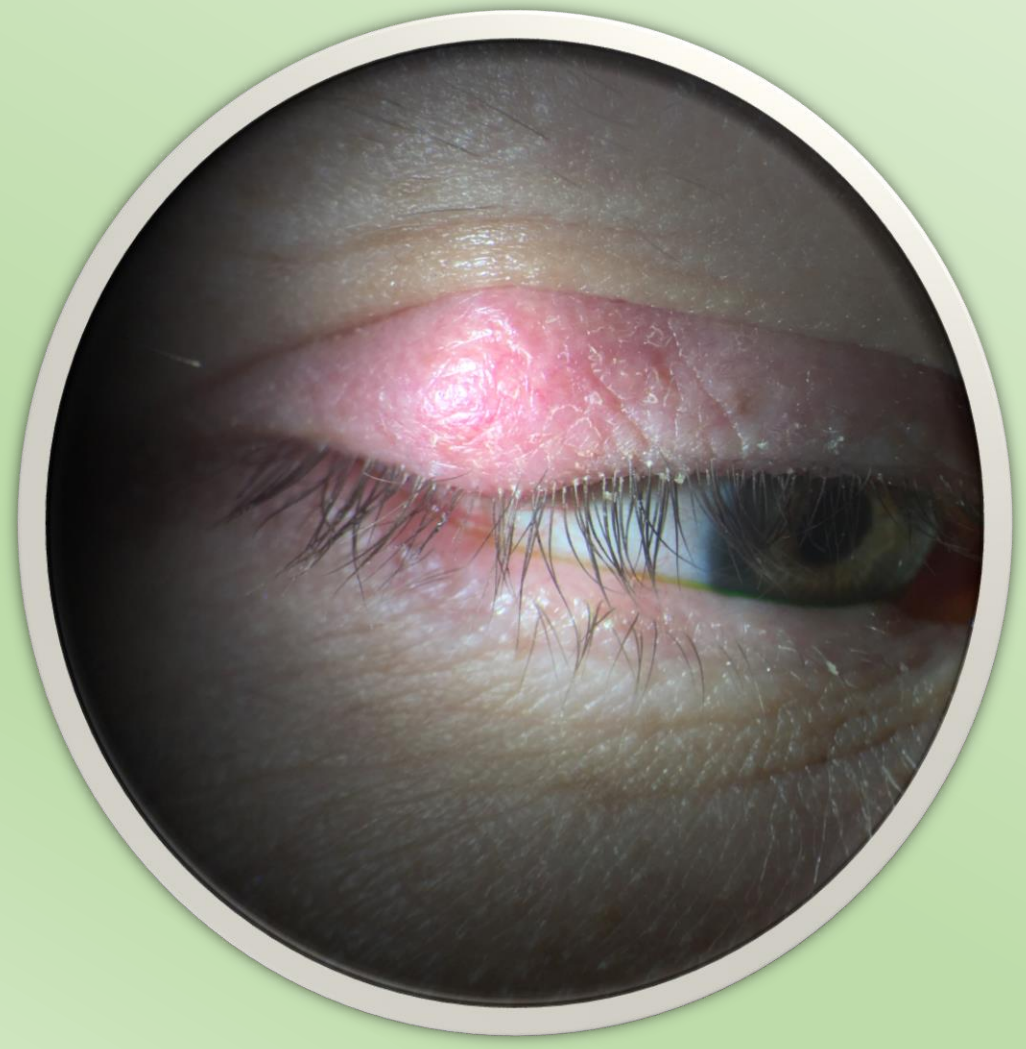
Px typically presents with the following:

- Painless lump
- Can sometimes caused blurred vision when lump presses on cornea

How patients might be managed:

- Hot compress to see if it resolves on its own
- Persistent chalazia or those inducing astigmatism may be referred to oculoplastics for removal

Lid Lump/Bumps: Internal/External Hordeolum



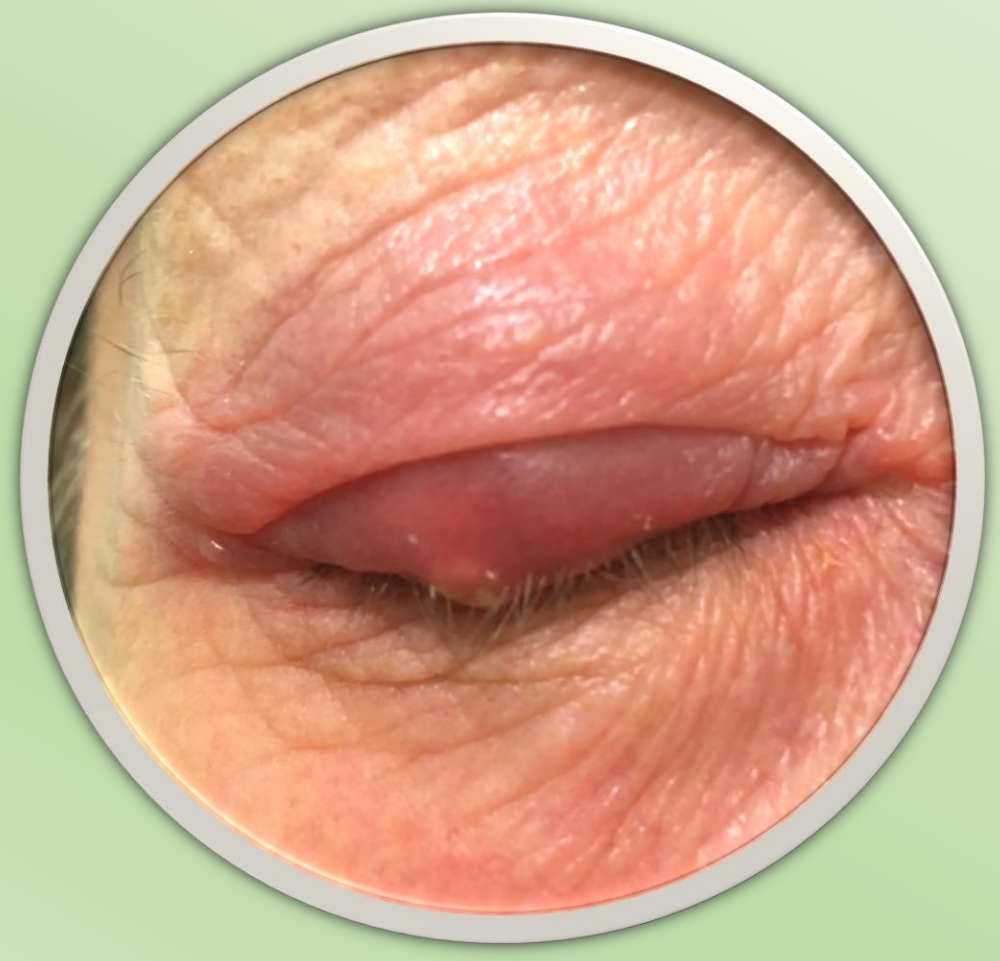
Px typically presents with the following:

- Painful tender eyelid lump
- Mucus discharge

How patients might be managed:

- Hot compress even after infection clears till lump resolves
- Antibiotics such as chloramphenicol

Lid Lump/Bumps: Preseptal Cellulitis



Px typically presents with the following:

- Swollen
- Redness extending across entire lid and possibly extending to forehead and cheek
- Normal vision
- No pain

How this patient might be managed:

- In children EMERGENCY same day to HES
- In adult's URGENT referral to GP/Ophthalmology for systemic antibiotics.

Lid Lump/Bumps: Orbital Cellulitis

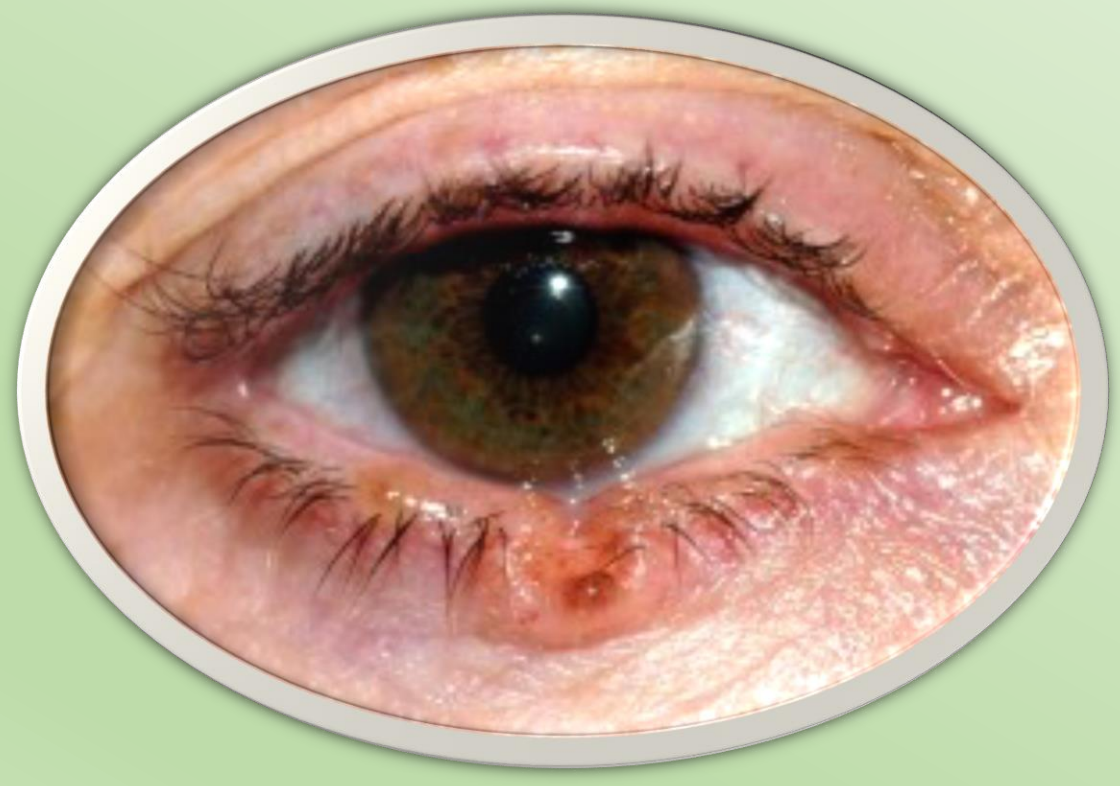
Px typically presents with the following:

- Swollen
- Redness extending across entire lid and possibly extending to forehead and cheek
- Reduced vison
- Double vision
- Pain on eye movement
- Eye bulging (proptosis)

How this patient might be managed:

- Emergency same day referral to HES

Lid Lump/Bumps: Basal Cell Carcinoma



Reference: www.bopss.co.uk

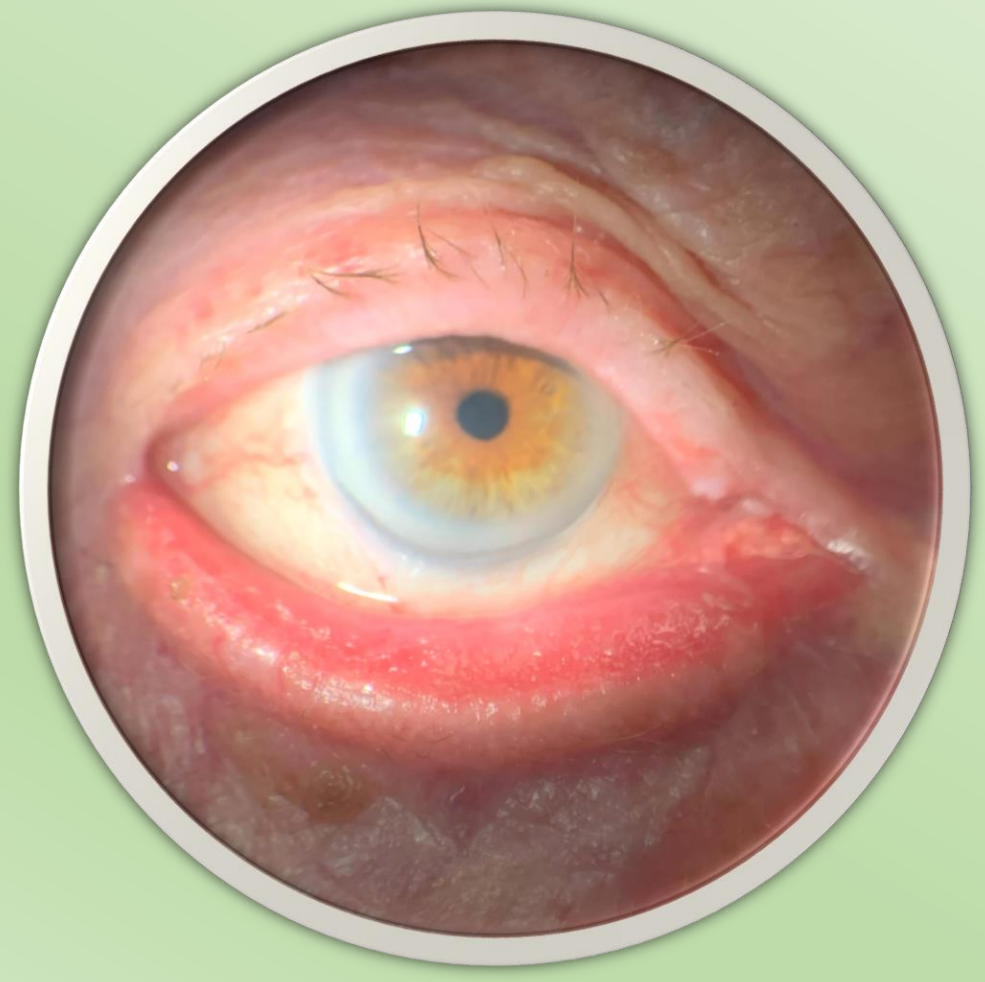
Px typically presents with the following:

- Slow growing lesion
- Persistent non-healing lesion
- Crusted lesion
- Ulcerated and bleeding

How the patient might be managed

-2 weeks referral pathway for excision and biopsy

Lids: Ectropion



Px typically presents with the following:

- Excessive watering
- Recurrent infections
- Soreness/irritation

How the patient might be managed:

- Short-term: lid taping, lubricants
- Long-term: referral for lid surgery

Lids: Entropion

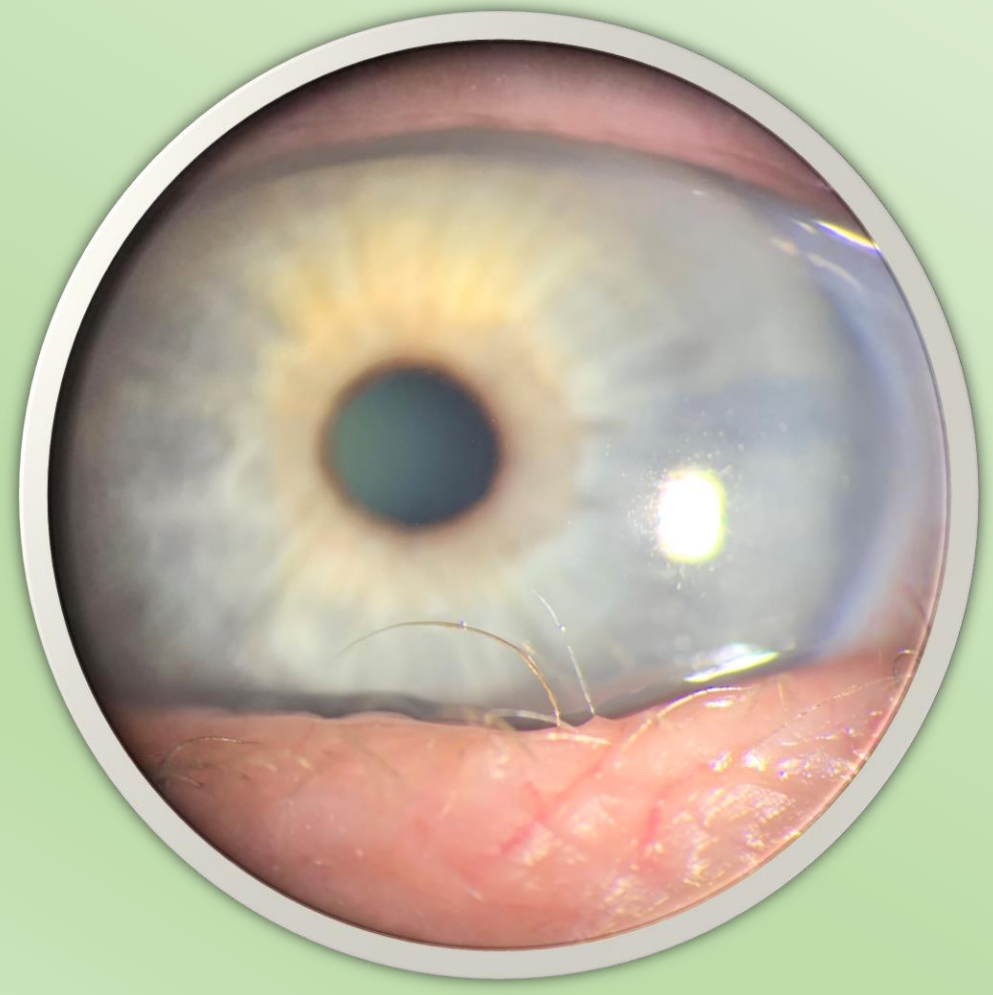
Px typically presents with the following:

- FB sensation
- Pain
- Photophobia
- Redness

How the patient might be managed:

- Short term: removes lashes, tape lids
- Long term: lid surgery more urgent than ectropion due to potential for corneal ulcers

Lids: Trichaisis



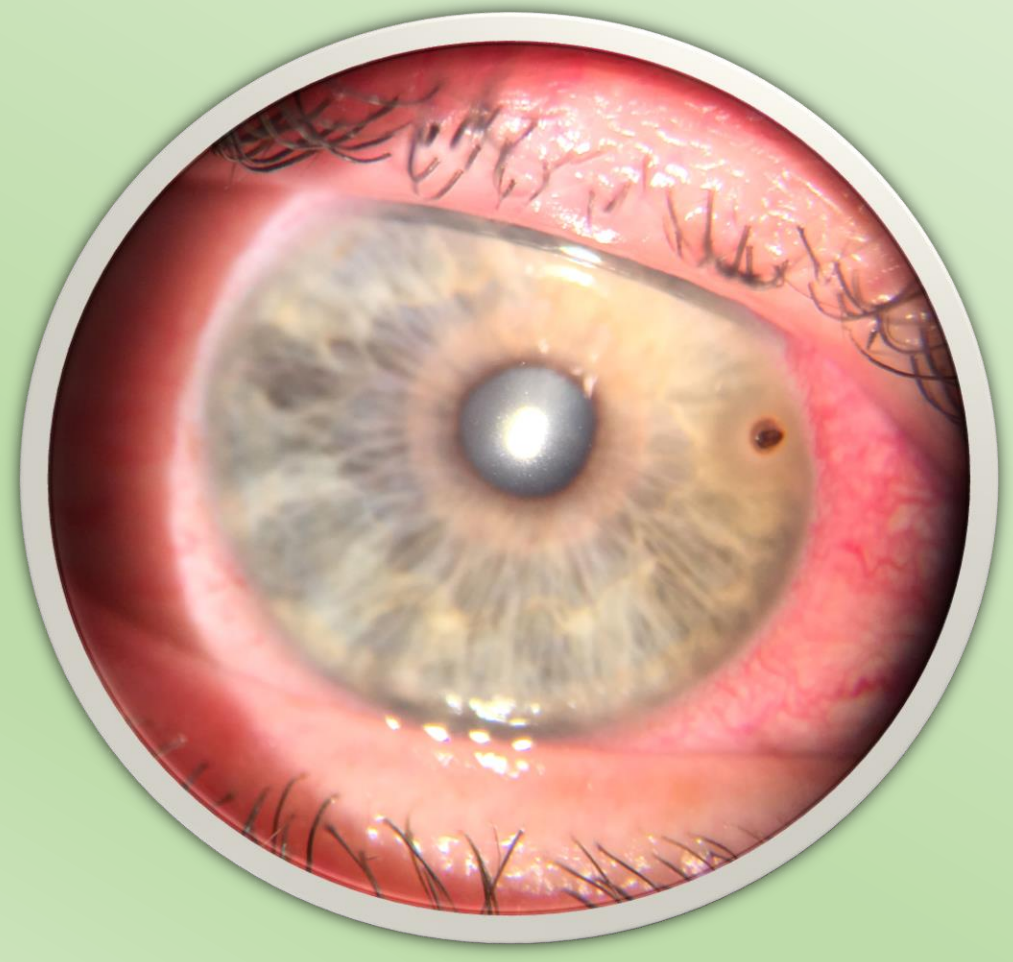
Px typically presents with the following:

- FB sensation
- Soreness/irritation
- Redness

How the patient might be managed:

- Short term: Epilation
- Long term: Electrolysis, Laser Ablation

Foreign Body Sensation: Embedded FB



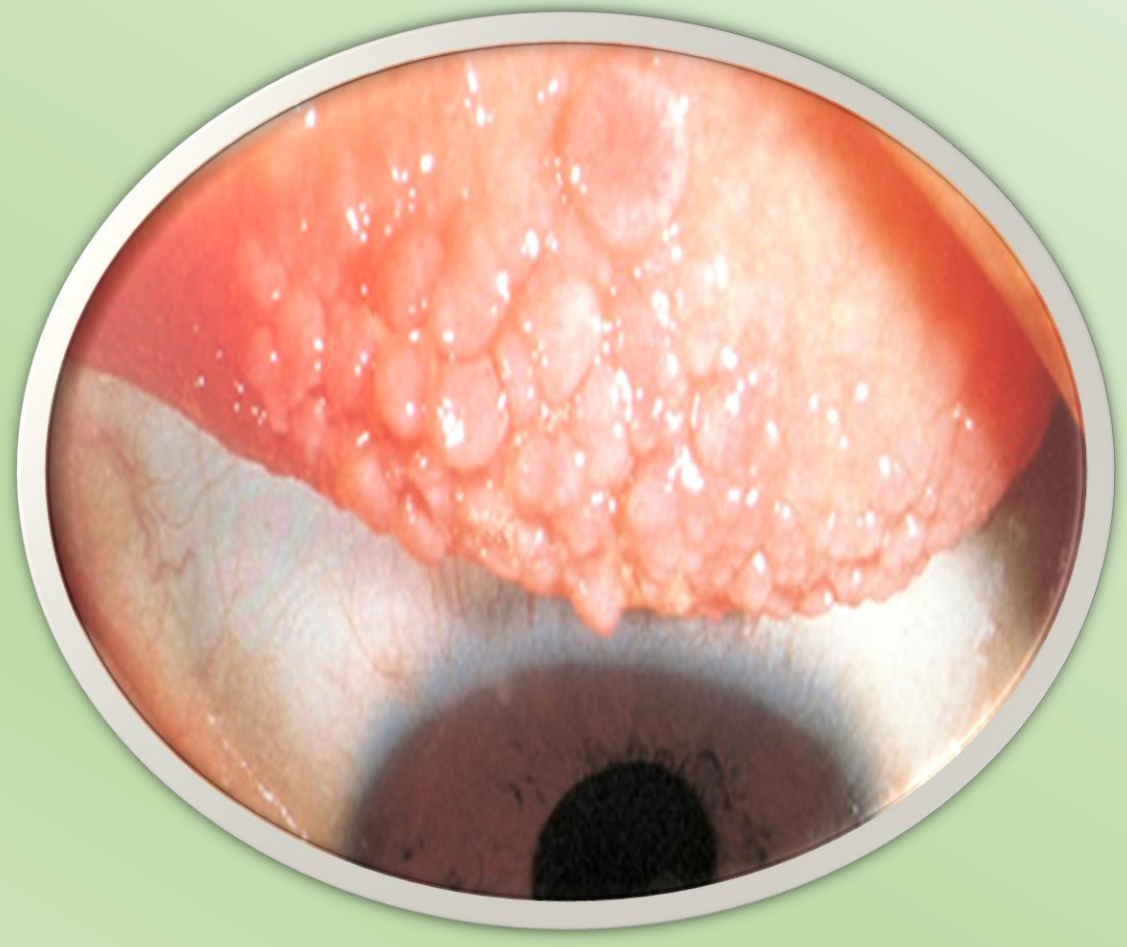
Px typically presents with the following:

- *Usually at 5:00 on a Friday Afternoon*
- Pain/Severe Pain
- Photophobic
- Unable to open eye
- Reduced Vision
- Excessive Watering
- Been doing an activity without safety eyewear
- Aware of black dot on cornea
- Often not patient first occurrence

How the patient might be managed:

- Removal with needle, PVA spear
- Refer for removal if central lesion or unable to remove in practice
- Refer for rust ring removal

Foreign Body Sensation: Giant Papillary Conjunctivitis



Px typically presents with the following:

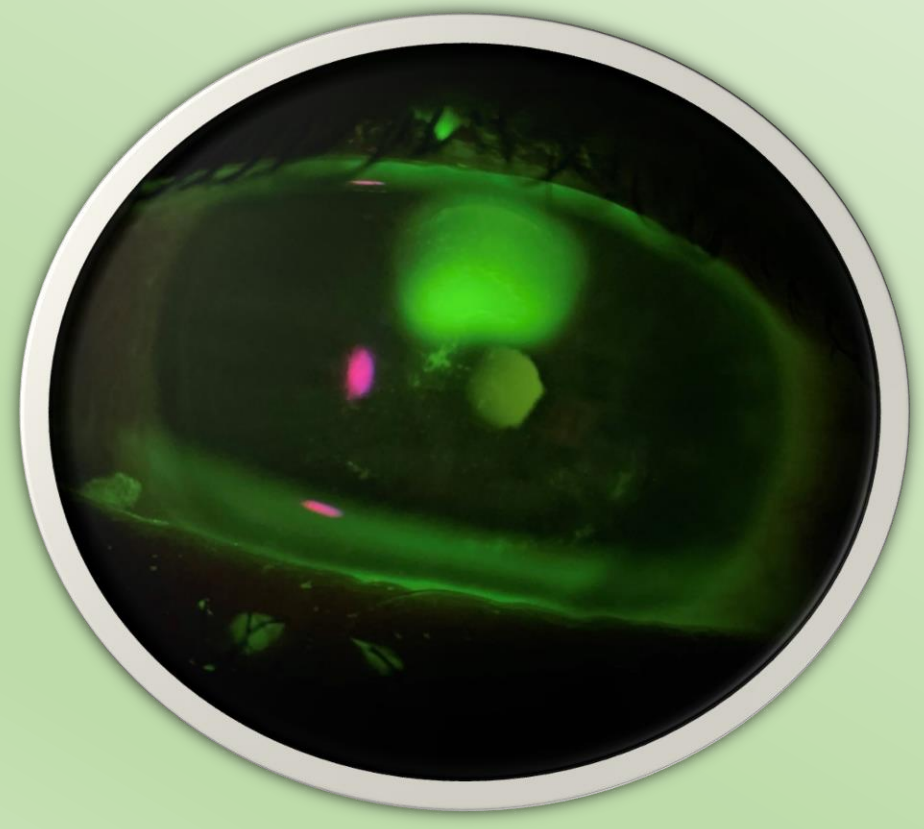
- Foreign body sensation particularly beneath upper eyelid
- Sore, Irritated eyes
- Seen in CL wearer or allergy suffers

How the patient might be managed:

- Cease CL wear until resolution and consider refitting with lower modulus lens
- Topical mast cell stabilisers or antihistamine with topical lubricants

Reference: American Academy of Ophthalmology aao.org

Trauma: Abrasion



Px typically presents with the following:

- Pain
- Photophobia
- Excessive watering
- Reduced vision
- Aware of recent injury

How the patient might be managed

- Close monitoring of healing and watch for infection
- Prophylactic antibiotics
- Lubricants
- May refer if deep abrasion or large defect

Trauma: Recurrent Corneal Erosion

Px typically presents with the following:

- Pain on waking which improves through the day
- Variable/reduced vision in morning
- History of injury

How the patient might be managed

- Gel lubricants morning and evening for at least 3 months following an episode
- Advice on recurrence in the future

Trauma: Chemical Injury

Px typically presents with the following:

- It is rare for these patient to present in practice
- Pain
- Photophobia
- Loss of vision
- Burns to eyelids and surrounding tissue

How the patient might be managed:

- First aid: Immediate irrigation for at least 15 minutes
- Emergency SAME DAY referral to HES for management.

How to Triage (Part 2)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

Px presenting with: (Circle as appropriate)		
Reduced Vision	Does it come and go or is it permanent?	Transient / Sustained
Distorted Vision	Did it come on gradually or suddenly?	Gradual / Sudden
Visual Disturbance	Any Pain? Pain Score	YES / NO / 10
Double Vision		
(Px will Require Dilation)	Any Headaches?	YES / NO

Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	→	YES — See within 48 HOURS
			NO — Go to Q.2
	Q.2 – If gradual, when did it start?	→	< 2 Months — See with 14 Days (Check with Optom)
			> 2 Months — See out of Pathway as Sight Test

Both transient or sustained reduced vision, require further investigation. It can indicate what condition the patient may have.

How to Triage (Part 2)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

Px presenting with: (Circle as appropriate)		
Reduced Vision **Distorted Vision** **Visual Disturbance** **Double Vision** ***(Px will Require Dilation)***	Does it come and go or is it permanent?	Transient / Sustained
	Did it come on gradually or suddenly?	Gradual / Sudden
	Any Pain? Pain Score	YES / NO / 10
	Any Headaches?	YES / NO

Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	→	**YES** — **See within 48 HOURS**
			NO — Go to Q.2
	Q.2 – If gradual, when did it start?	→	< 2 Months — See with 14 Days (Check with Optom)
			> 2 Months — See out of Pathway as Sight Test

Gradual onset reduction in vision may fall under the remit of an early eye examination rather than a MECS appointment.

Sudden onset symptoms increase the urgency in which the patient needs to be assessed.

How to Triage (Part 2)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

Px presenting with: (Circle as appropriate)		
Reduced Vision	Does it come and go or is it permanent?	Transient / Sustained
Distorted Vision	Did it come on gradually or suddenly?	Gradual / Sudden
Visual Disturbance	Any Pain? Pain Score	YES / NO / 10
Double Vision		
(Px will Require Dilation)	Any Headaches?	YES / NO

Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	→	YES: See within 48 HOURS
			NO: Go to Q.2
	Q.2 – If gradual, when did it start?	→	< 2 Months: See with 14 Days (Check with Optom)
			> 2 Months: See out of Pathway as Sight Test

Painful loss of vision, helps the Optometrist discern what condition the patient may have and establish urgency of assessment

How to Triage (Part 2)

In relation to the symptoms, these are useful questions to ask in order to establish urgency.

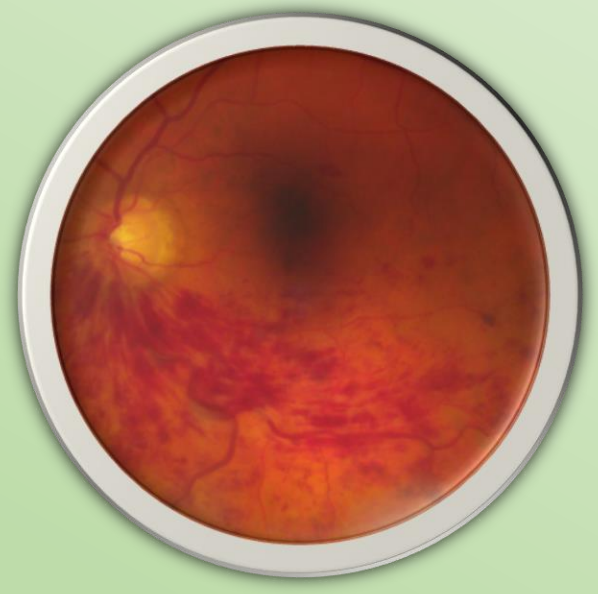
Px presenting with: (Circle as appropriate)		
Reduced Vision	Does it come and go or is it permanent?	Transient / Sustained
Distorted Vision	Did it come on gradually or suddenly?	Gradual / Sudden
Visual Disturbance	Any Pain? Pain Score	YES / NO / 10
Double Vision		
(Px will Require Dilation)	Any Headaches?	YES / NO

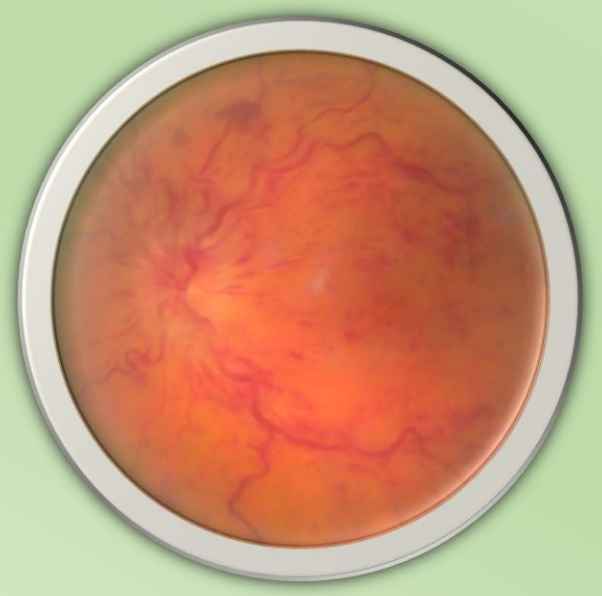
Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	→	YES: **See within 48 HOURS**
			NO: Go to Q.2
	Q.2 – If gradual, when did it start?	→	< 2 Months: See with 14 Days (Check with Optom)
			> 2 Months: See out of Pathway as Sight Test

Headaches in conjunction with visual loss helps establish urgency at which patient needs to be seen.

Headaches in absence of other symptoms, may fall more under the remit of early examination or further assessment by GP.

Loss of Vision: BRVO/CRVO





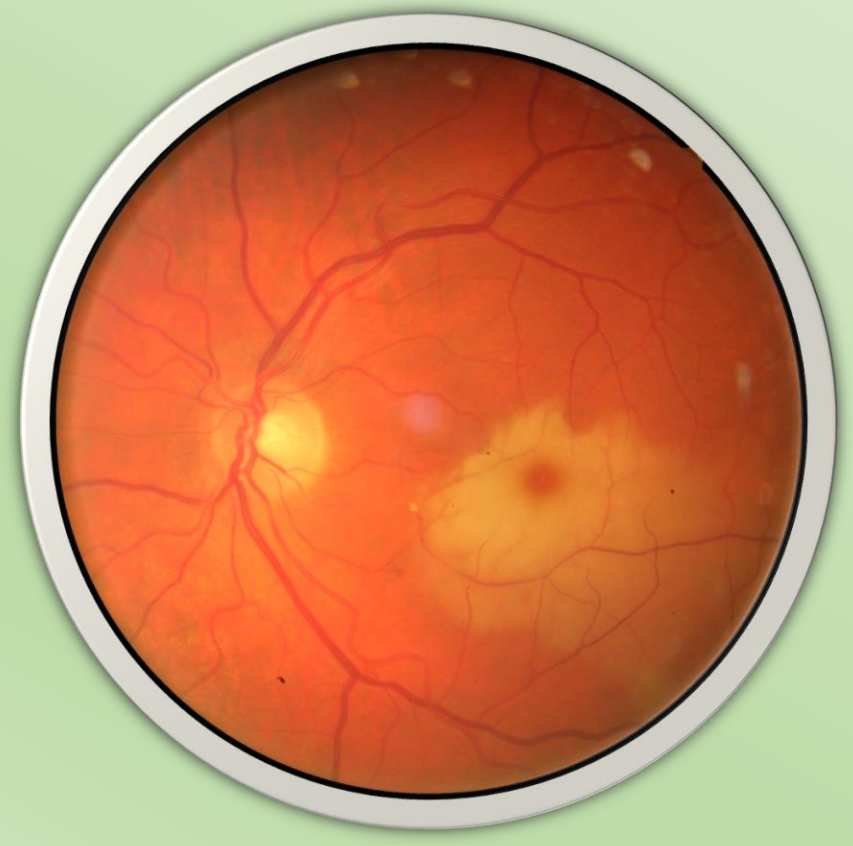
Px typically presents with the following:

- Painless
- Unilateral Loss of vision
- Can be asymptomatic if macula isn't involved

How the patient might be managed:

- Urgent GP assessment for BP and bloods to establish underlying cause
- Urgent HES assessment for associated macula oedema

Loss of Vision: BRAO/CRAO



Px typically presents with the following:

- Sudden
- Painless
- Profound partial or complete loss of vision

How the patient might be managed:

- Laying patient down
- CO2 rebreathing (breathing into paper bag)
- Globe Massage
- Emergency to HES

Loss of Vision: Amaurosis Fugax (TIA)

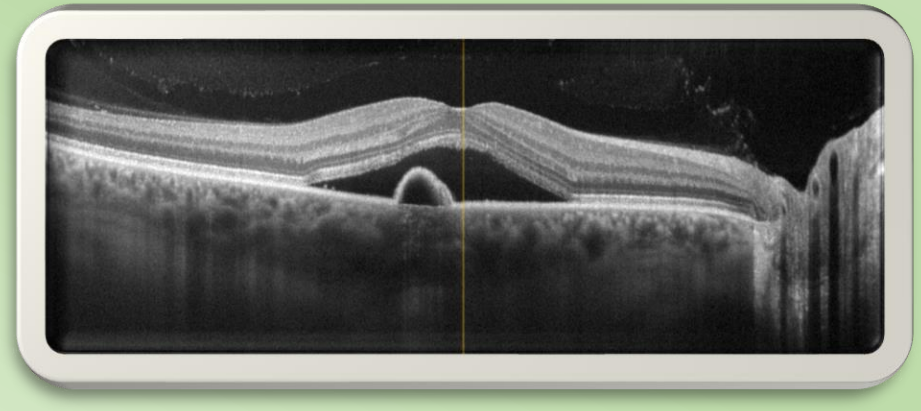
Px typically presents with the following:

- Transient complete loss of vision
- Last a few seconds
- Painless

How the patient might be managed:

- Emergency assessment by TIA pathway as can indicate imminent stroke

Loss of Vision: Central Serous Retinopathy



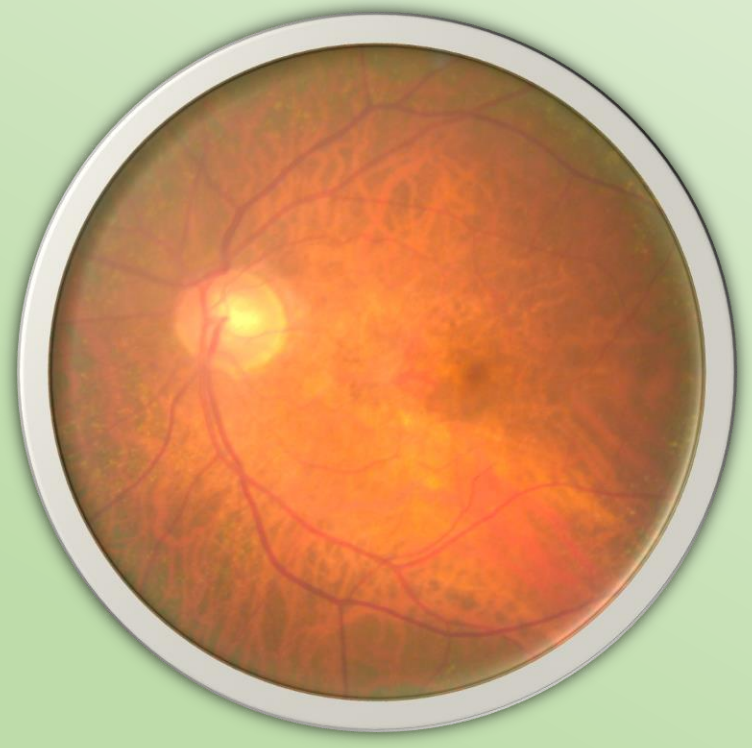
Px typically presents with the following:

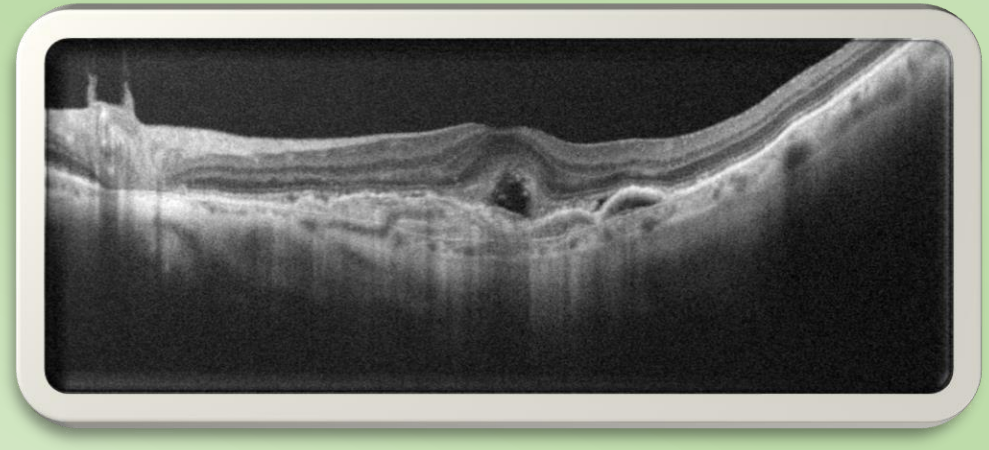
- Central visual distortion
- Central bubble in vision
- Sudden or gradual over a few weeks
- Painless

How the patients might be managed:

- Usually seen in high stress individuals
- Can resolve with removal of cause (getting stress under control)
- Referral to medical retina clinic

Loss of Vision: Wet AMD





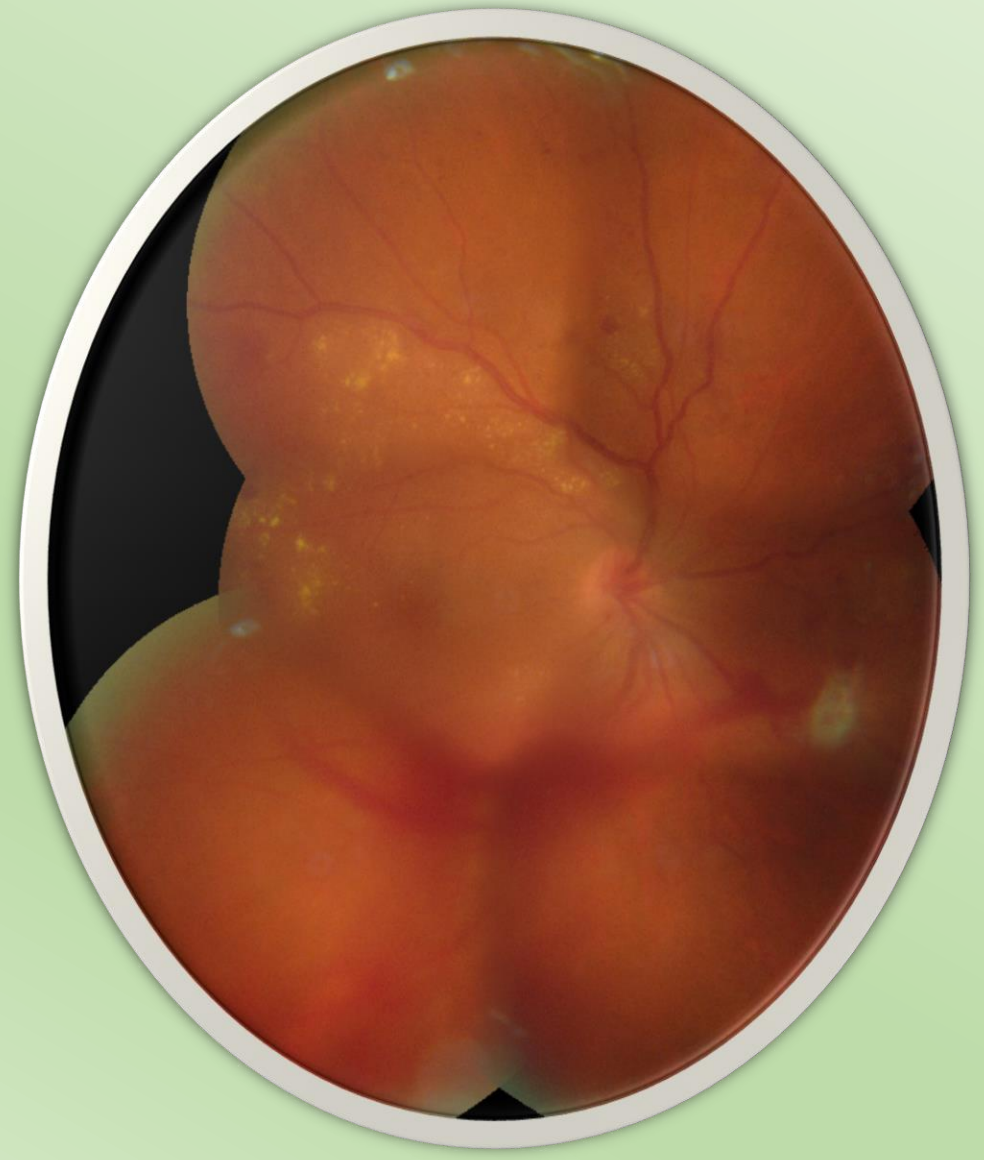
Px typically presents with the following:

- Sudden drop in vision
- Central visual distortion
- Painless

How the patient might be managed:

- RAPID ACCESS referral for IV injections

Loss of Vision: Vitreous Haemorrhage



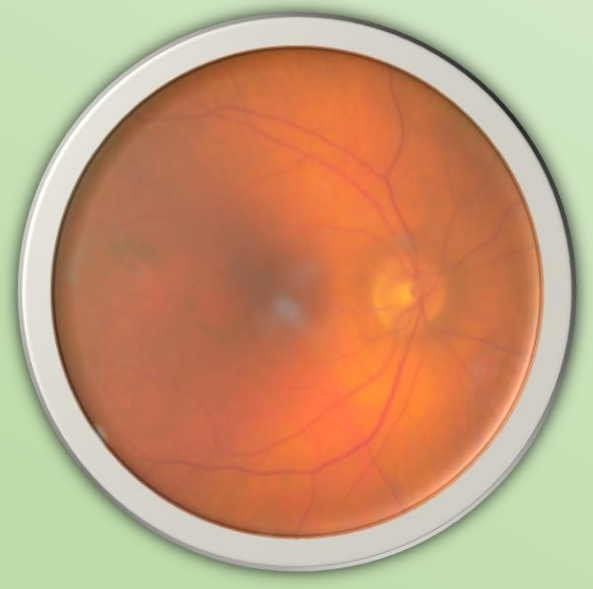
Px typically presents with the following:

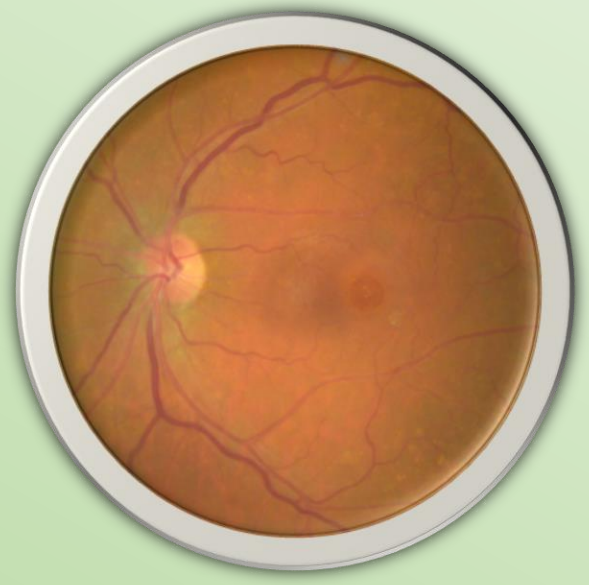
- Sudden
- Painless
- Profound Loss of Vision
- Red/Brown Haze over vision

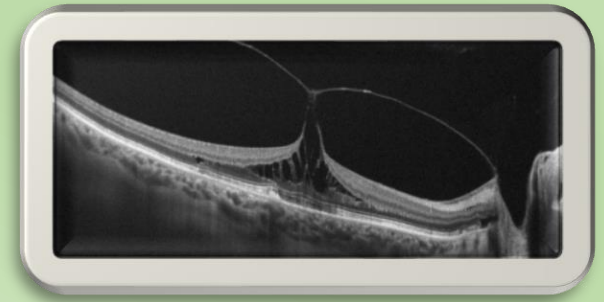
How the patient might be managed:

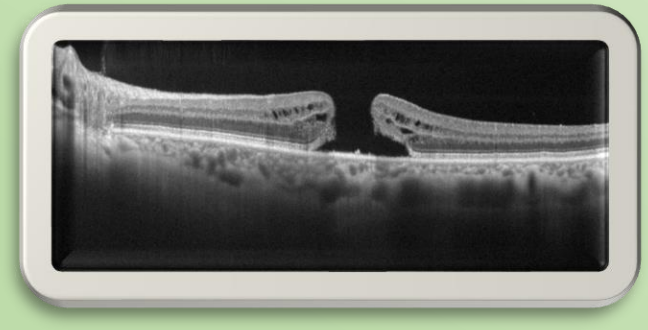
- Emergency Referral to HES
- Due to difficulties of assessment, ultrasound needed to rule out retinal break/detachment

Loss of Vision: VMT/Macular Hole









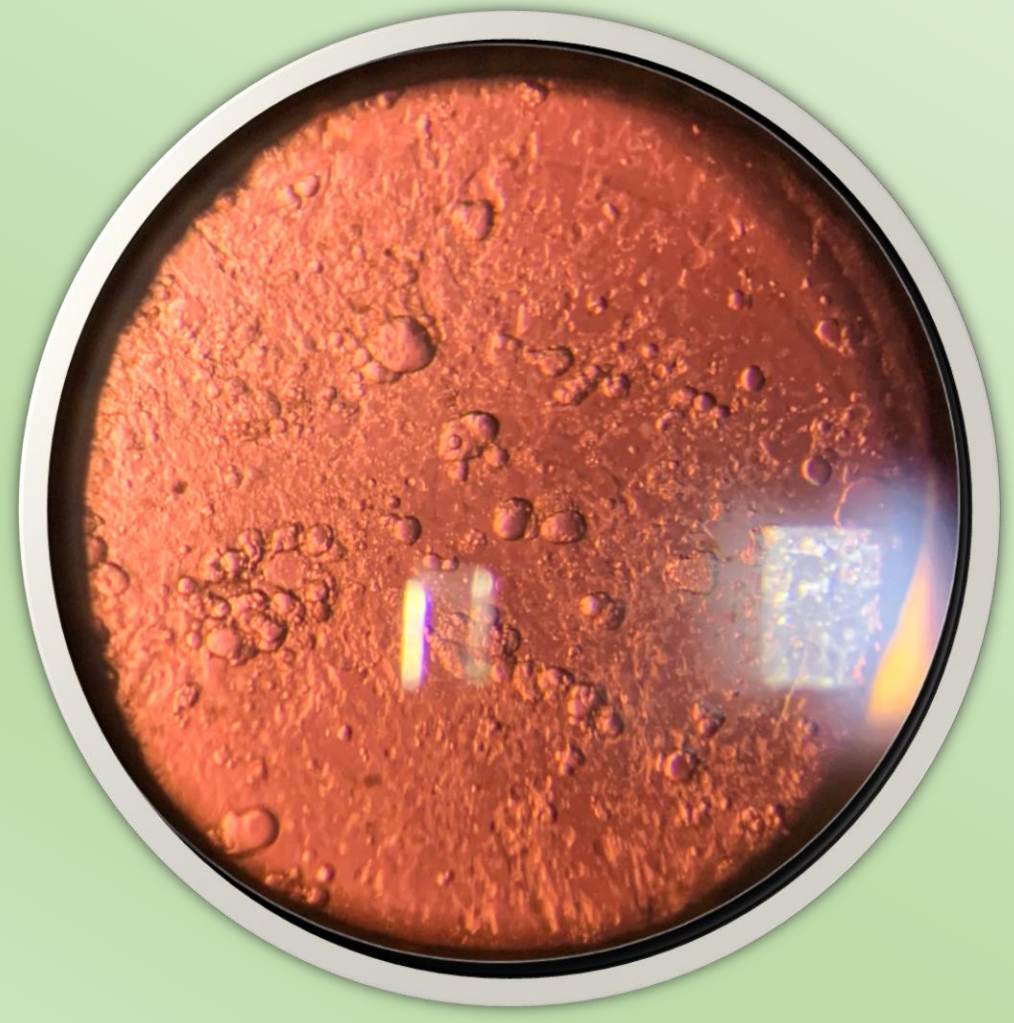
Px typically presents with the following:

- Sudden onset central loss of vision
- Central distorted vision
- Photopsia
- Asymptomatic

How patient might be managed:

- Can spontaneously resolve without issue
- Referral to VR clinic for monitoring or surgery in case of macular hole

Loss of Vision: PCO



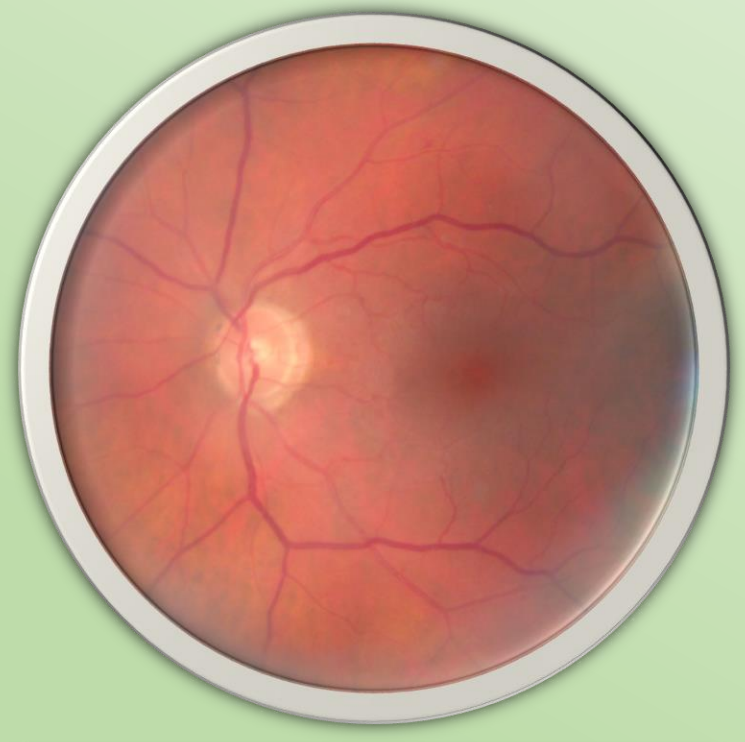
Px typically presents with the following:

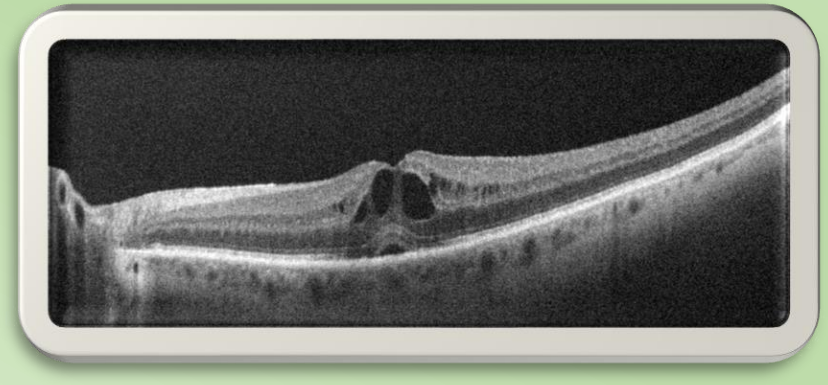
- Gradual onset
- Clouding of vision
- Patient often describes ‘feel like cataract coming back’

How patient might be managed:

- Referral for YAG laser

Loss of Vision: CMO





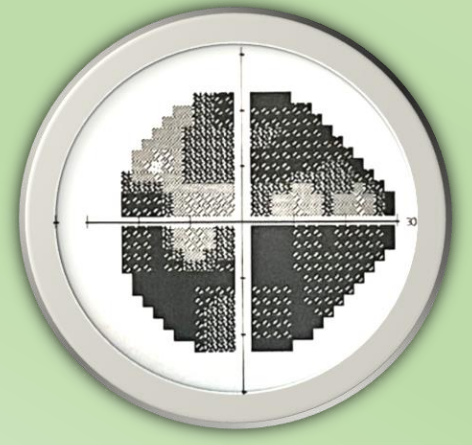
Px typically presents with the following:

- Central visual disturbance
- Blurring/Reduction of vision
- Gradual or Sudden onset

How the patient might be managed:

- Commonly seen post cataract
- Referral for steroid management

Loss of Vision: ION



Px typically presents with the following:

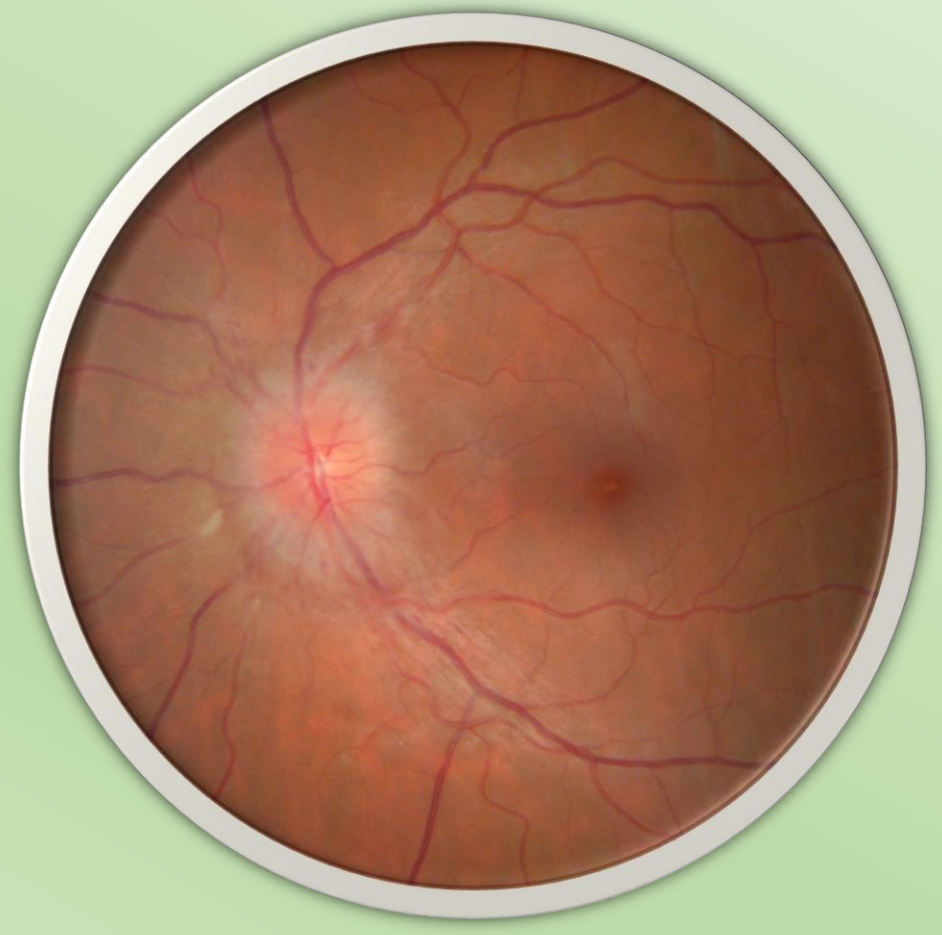
- Headache
- Scalp tenderness
- Jaw claudication
- Reduced vision to profound visual loss
- Marked VF defect (loss of top/bottom half of vision)

How this patient might be managed:

- Emergency same day referral to HES

TRUE EMERGENCY needs treatment without delay

Loss of Vision: Optic Neuritis



Px typically presents with the following:

- Pain on eye movement
- Reduced Vision

How this patient might be managed:

- Urgent Referral to HES

Visual Disturbance: Migraine Visual Aura

Px typically presents with the following:

- Photopsia
- Kaleidoscope/zig zag disturbance in vision
- Start off small increasing in size before disappearing
- Typical last around 15 minutes
- With/without headache following

How the patient might be managed:

- Referral to GP for migraine relief medication if persistent issue
- Dilated assessment to rule out retina related flashes.

Double Vision: Gradual Onset/Intermittent Symptoms

Gradual onset or transient diplopia may fall into the category of early GOS examination instead of MECS assessment.

Sudden onset diplopia often requires urgent assessment directly at HES or with GP and isn’t covered by most MECS schemes, as typically patients require neurological assessment and ophthalmological assessment.

Double Vision: 3rd Nerve Palsy (Complete, Partial, with/without pupil involvement)

Px typically presents with the following:

- Sudden onset
- Ptosis of eyelid (may mask double vision)
- Eye in down and out position with severe muscle restriction
- With/without enlarged pupil

How this patient might be managed:

- Emergency Referral to HES (with pupil involvement indicates higher urgency)

Double Vision: 4th Nerve Palsy

Px typically presents with the following:

- Sudden onset
- Affected eye higher (hypertropia)
- Patient may tilt head to prevent double vision

How this patient might be managed:

- Emergency Referral to HES

Double Vision: 6th Nerve Palsy

Px typically presents with the following:

- Horizontal double vision
- Affected eye turns in
- Most susceptible nerve to trauma

How the patient might be managed:

- Emergency Referral to HES

Double Vision: Orbital Fracture

Px typically presents with the following:

- Recent trauma to the globe
- Diplopia on up and down gaze

How the patient might be managed:

- Emergency Referral to HES

How to Triage (Part 3)

Px presenting with **Floaters / Flashes**: ***(Px will Require Dilation)***					
Do you have floaters in your vision?	YES / NO	Do you have any flashing lights in your vision?	YES / NO	Do you have a shadow, curtain, or veil in your vision?	YES / NO
If Yes, have you always had floaters?	YES / NO		Right / Left / Both		Right / Left / Both
If Yes, do you have? (delete as appropriate)	NEW FLOATERS INCREASING FLOATERS STABLE FLOATERS	How long does the flashing in your vision last?		Do you have any reduction or change in vision	YES / NO

Flashes and / or Floaters ***WILL REQUIRE DILATION***	**Q.1 – What are your symptoms?**	Floaters / Flashes / Both	**Q.4 – When did your symptoms start, change or worsen?**	**< 6 Weeks**	**See within 24 HOURS**
	Q.2 – If just floaters, have you always had floaters?	YES (Move to Q.3)		6 Weeks to 2 Months Stable Symptoms	See within 14 Days (Check with Optom First)
		NO (Move to Q.4)		**6 Weeks to 2 Months Increasing Symptoms**	**See within 24 HOURS**
	Q.3 – If patient has always had floaters, are they?	Stable / New Floaters / Increase		>2 Months	Likely to exit pathway (Check with Optom First)

Floaters are common in most people however new onset floaters or increasing floaters need to be investigated with urgency, to rule out serious retinal issues.

Floaters noticed within 6 weeks are generally considered new onset

It is important to get the patient to describe the floaters they're seeing, as this can indicate to the Optometrist what condition the patient may have

How to Triage (Part 3)

Px presenting with **Floaters / Flashes**: *(Px will Require Dilation)*					
Do you have floaters in your vision?	YES / NO	Do you have any flashing lights in your vision?	YES / NO	Do you have a shadow, curtain, or veil in your vision?	YES / NO
If Yes, have you always had floaters?	YES / NO		Right / Left / Both		Right / Left / Both
If Yes, do you have? (delete as appropriate)	NEW FLOATERS INCREASING FLOATERS STABLE FLOATERS	How long does the flashing in your vision last?		Do you have any reduction or change in vision	YES / NO

Flashes and / or Floaters ***WILL REQUIRE DILATION***	**Q.1 – What are your symptoms?**	Floaters / Flashes / Both	**Q.4 – When did your symptoms start, change or worsen?**	**< 6 Weeks**	**See within 24 HOURS**
	Q.2 – If just floaters, have you always had floaters?	YES (Move to Q.3)		6 Weeks to 2 Months Stable Symptoms	See within 14 Days (Check with Optom First)
		NO (Move to Q.4)		**6 Weeks to 2 Months Increasing Symptoms**	**See within 24 HOURS**
	Q.3 – If patient has always had floaters, are they?	Stable / New Floaters / Increase		>2 Months	Likely to exit pathway (Check with Optom First)

The key differentials for flashing in vision are migraine visual aura or retina related flashing.

Unilateral flashing is usually retinal in origin. Bilateral or unable to distinguish generally indicates migraine type flashing.

Duration of flashing is key in differentiating what kind of flashing the patient is suffering with. Quick flashing lasting a few seconds, on the edge of vision, typically in an evening is usually retinal in origin.

Central visual disturbance lasting around 15 mins is more likely to be a migraine visual aura

How to Triage (Part 3)

Px presenting with **Floaters / Flashes**: ***(Px will Require Dilation)***					
Do you have floaters in your vision?	YES / NO	Do you have any flashing lights in your vision?	YES / NO	Do you have a shadow, curtain, or veil in your vision?	YES / NO
If Yes, have you always had floaters?	YES / NO		Right / Left / Both		Right / Left / Both
If Yes, do you have? (delete as appropriate)	NEW FLOATERS INCREASING FLOATERS STABLE FLOATERS	How long does the flashing in your vision last?		Do you have any reduction or change in vision	YES / NO

Flashes and / or Floaters ***WILL REQUIRE DILATION***	**Q.1 – What are your symptoms?**	Floaters / Flashes / Both	**Q.4 – When did your symptoms start, change or worsen?**	**< 6 Weeks**	**See within 24 HOURS**
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	Q.3 – If patient has always had floaters, are they?	Stable / New Floaters / Increase		>2 Months	Likely to exit pathway (Check with Optom First)

Presence of a shadow in vision and/or reduction indicate serious retinal pathology may be present. Patient requires urgent assessment to determine if pathology is present.

Some schemes advise that if patient complains of curtain/veil in vision they should be seen directly at HES.

Patients presenting c/o the following should be assessed without delay to avoid preventable sight loss

Flashes: Migraine Visual Aura

Px typically presents with the following:

- Photopsia
- Kaleidoscope/zig zag disturbance in vision
- Start off small increasing in size before disappearing
- Typical last around 15 minutes
- With/without headache following

How the patient might be managed:

- Referral to GP for migraine relief medication if persistent issue
- Dilated assessment to rule out retina related flashes.

F&F: Posterior Vitreous Detachment

Px typically presents with the following:

- Flashing on edge of vision – usually in evenings
- New onset floaters
- Donut or black blob in vision
- Spider, cobweb or hair in vision

How patient might be managed:

- Dilated visual assessment to rule out retinal break
- Emergency advice following diagnosis in case symptoms change

F&F: Retinal Tear/Hole

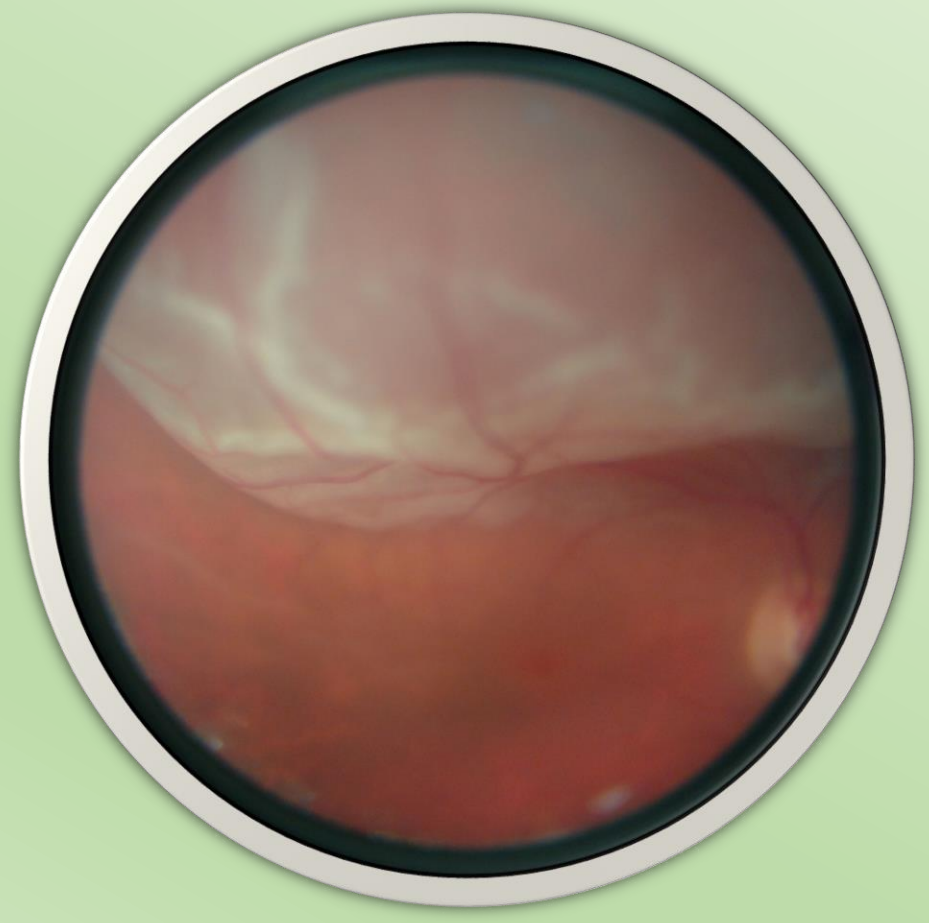
Px typically presents with the following:

- Flashing on edge of vision – usually in evenings
- New onset floaters:
- Donut or black blob in vision
- Spider, cobweb or hair in vision
- Symptoms of PVD with or without retinal break are indistinguishable so all patients require urgent assessment

How patient might be managed:

- Dilated assessment
- Emergency referral

F&F: Retinal Detachment



Px typically presents with the following:

- Flashing on edge of vision – usually in evenings
- New onset floaters:
- Donut or black blob in vision
- Spider, cobweb or hair in vision
- Shadow or curtain in vision
- Reduced vision (macular integrity compromised)
- Symptoms of PVD with or without retinal break/detachment are often indistinguishable so all patients require urgent assessment

How patient might be managed:

- Dilated assessment
- Emergency referral, macula on more time sensitive than macula off

Bringing Everything Together

Depending on how your local scheme operates, some determine the time frame dependent on the symptoms mentioned.

Others require an Optometrist to review the symptoms and specify a suitable timeframe in which the patient needs to be seen.

In some instances, patients should first be directed to self-care before attending appointments for persistent issues.

For symptoms outside the remit of MECS/CUES it is important to record who you have directed the patient to and the reason why.

It is useful to prepare patients of what to expect prior to the appointment.

Bringing Everything Together

Reason for Referral (Presenting Symptoms)

Which Eye?	Right / Left / Both
When did it start?	
Are you a CL Wearer?	YES / NO

Additional Questions

Px presenting with: (Circle as appropriate)			Px presenting with: (Circle as appropriate)		
Red Eye **Painful Eye** **Sore / Irritated Eye** **Itchy Eye** **Eyelid Lump / Bump** **Foreign Body** **Trauma**	Is it Painful? Pain Score:	YES / NO / 10	**Reduced Vision** **Distorted Vision** **Visual Disturbance** **Double Vision** ***(Px will Require Dilation)***	Does it come and go or is it permanent?	Transient / Sustained
	Are you sensitive to Light?	YES / NO		Did it come on gradually or suddenly?	Gradual / Sudden
	Is there any change in Vision?	YES / NO		Any Pain? Pain Score	YES / NO / 10
	Have you had any recent eye surgery?	YES / NO When:		Any Headaches?	YES / NO

Px presenting with **Floaters / Flashes**: ***(Px will Require Dilation)***					
Do you have floaters in your vision?	YES / NO	Do you have any flashing lights in your vision?	YES / NO Right / Left / Both	Do you have a shadow, curtain, or veil in your vision?	YES / NO Right / Left / Both
If Yes, have you always had floaters?	YES / NO				
If Yes, do you have? (delete as appropriate)	NEW FLOATERS INCREASING FLOATERS STABLE FLOATERS	How long does the flashing in your vision last?		Do you have any reduction or change in vision	YES / NO

This section to be completed by Optometrist.

Outcome

URGENT MECS within 24 Hours	*ROUTINE MECS within 5 Days*	*Not suitable for MECS*

Appointment Type

MECS SCHEME *No Charge*	*PRIVATE MECS (Anterior Eye)* *£25.00*	*PRIVATE MECS (Posterior Eye inc. OCT)* *£35.00*

Pre-screening Required Prior to Appointment

Autos		*IOPs*		*Fundus Pics*		*OCT*		*Fields (specify test)*	

ACTION & ADVICE (Px unsuitable for MECS or unable to be seen within time frame)

Eye Casualty		*GP*		*Pharmacy*		*No Referral Necessary*	

Notes:

Optom Name:		*Optom Signature:*	

Appointment Confirmation

Date:	/ /	*Time:*		***Dilation Required? (Optom)***		*Dilation Px Told not to DRIVE*		*If PRIVATE MECS Advised of Charge*	

Reason for Referral (presenting symptoms):

Which Eye?	Right / Left / Both
When did it Start?	
Are you a CL Wearer?	Yes / No

Eye Pain Eye Discomfort Sore / Irritated Eye Red Eye Dry Eye Watery Eye Eye Lumps / Bumps	**Q.1 – Is it Painful?**	**YES**	**See within 24 HOURS**
		NO	Go to Q.2
	Q.2 – Is there sensitivity to light?	**YES**	**See within 24 HOURS**
		NO	Go to Q.3
	Q.3 - Is there any change in vision?	**YES**	**See within 48 HOURS**
		NO	See within 14 Days (Check with Optom)
Reduced Vision Disturbed Vision Distorted Vision (check with Optom) ***WILL REQUIRE DILATION***	**Q.1 – Has it developed suddenly?**	**YES**	**See within 48 HOURS**
		NO	Go to Q.2
	Q.2 – If gradual, when did it start?	< 2 Months	See with 14 Days (Check with Optom)
		> 2 Months	See out of Pathway as Sight Test

Flashes and / or Floaters ***WILL REQUIRE DILATION***	**Q.1 – What are your symptoms?**	Floaters / Flashes / Both	**Q.4 – When did your symptoms start, change or worsen?**	**< 6 Weeks**	**See within 24 HOURS**
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	Q.3 – If patient has always had floaters, are they?	Stable / New Floaters / Increase		>2 Months	Likely to exit pathway (Check with Optom First)

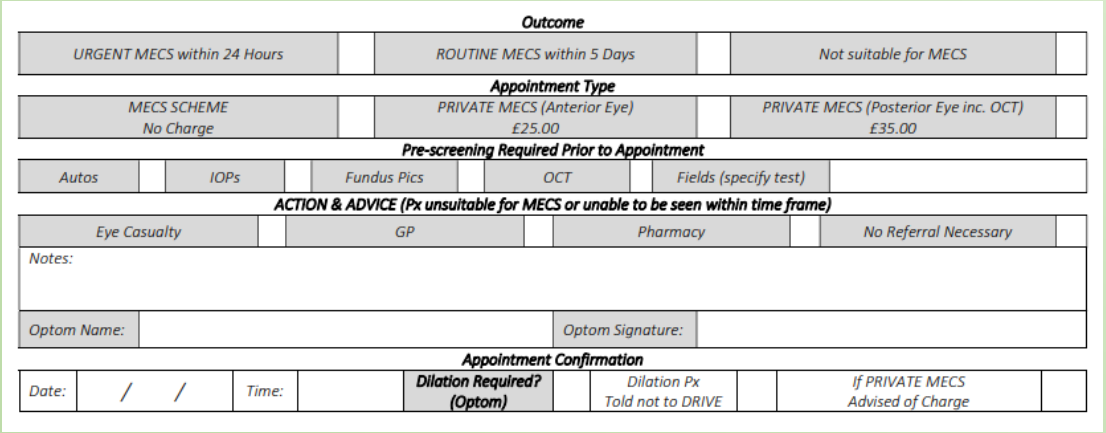
Advice Given	You should advise the patient to contact you at any time if symptoms become worse, or if out of hours, then contact GP or NHS 111 for further guidance. If no other advice is available then the patient should know to go to a hospital A & E Eye Department, or to seek medical advice in any event if they are generally unwell.
Action Taken if unable to see patient	

Appointment Date		Appointment Time	

Appointment Checklist

Patient advised DO NOT TO DRIVE: ***Mandatory for ALL DILATIONS***	**YES / NO**
Patient Requiring DILATION told to arrive 35 mins before: ➢ **FLASHES AND FLOATER** ➢ **REDUCED/DISTORTED VISION**	**YES / NO**
Is patient able to climb stairs? (Step Free Access) ➢ If **NO** - see Optom **BEFORE** booking appointment ➢ Offer these patients KMB as first choice	YES / NO
If PRIVATE MECS, Told £25 Charge	YES / NO

Empowering the Patient



Outcome

URGENT MECS within 24 Hours		ROUTINE MECS within 5 Days		Not suitable for MECS	

Appointment Type

MECS SCHEME No Charge		PRIVATE MECS (Anterior Eye) £25.00		PRIVATE MECS (Posterior Eye inc. OCT) £35.00	

Pre-screening Required Prior to Appointment

Autos		IOPs		Fundus Pics		OCT		Fields (specify test)	

ACTION & ADVICE (Px unsuitable for MECS or unable to be seen within time frame)

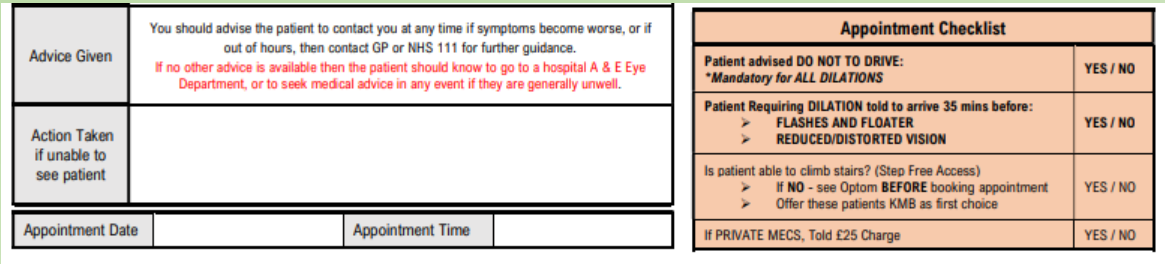
Eye Casualty		GP		Pharmacy		No Referral Necessary	

Notes:

Optom Name:		Optom Signature:	

Appointment Confirmation

Date: / /	Time:	**Dilation Required? (Optom)**		Dilation Px Told not to DRIVE		If PRIVATE MECS Advised of Charge	



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Action Taken if unable to see patient	

Appointment Date		Appointment Time	

Appointment Checklist	
Patient advised DO NOT TO DRIVE: ***Mandatory for ALL DILATIONS***	**YES / NO**
Patient Requiring DILATION told to arrive 35 mins before: ➢ **FLASHES AND FLOATER** ➢ **REDUCED/DISTORTED VISION**	**YES / NO**
Is patient able to climb stairs? (Step Free Access) ➢ If **NO** - see Optom **BEFORE** booking appointment ➢ Offer these patients KMB as first choice	YES / NO
If PRIVATE MECS, Told £25 Charge	YES / NO

A pre-visit checklist to prepare the patient ahead of time is useful to allow for efficient use of time and resources in practice.

For some emergency appointments patients require dilation, which means they cannot drive for several hours afterwards. It is important to inform patients as this allows them to make arrangements.

Patients should be given suitable emergency advice in the event their symptoms change or worsen prior to the appointment, or if symptoms persist despite self-care.

Who is responsible for the patient?

The practice who triages the patient assumes responsibility for making an appointment for the patient.

If you are unable to see the patient in the allotted timeframe, then you should call local practices on the scheme to see if they can see the patient.

If no practices can see the patient, then typically you have a hospital triage service the patient can then use to be seen at the HES.

What to do if the patient declines an appointment?

You will find situations where patients decline to be seen within the specified timeframe.

In this situation it is important to reiterate to the patient that you are required to see the patient within the specified timeframe in order to assess the eye and manage any problems in a timely manner.

If patients continue to decline you MUST make clear notes that you have offered an appointment within the timeframe, but patient has declined.

You must give the patient EMERGENCY advice to call back or seek medical attention if their symptoms change or worsen.

In situations where patients aren't entitled to funded services and decline due to a private charge you must direct them to a suitable alternative (GP or HES).

What triage processes do you currently have in practice?

Any Questions?