GO PUBLIC!

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

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Ophthalmology and Optometry Referral Guidelines

Ophthalmology/Optometry Clinic Location:	Valley Specialty Center 3rd floor 751 S. Bascom Ave.
Ophthalmology/Optometry Clinic Phone:	(408) 793-2525
Ophthalmology/Optometry Clinic Fax:	(408) 885-5849

This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.

E-CONSULT DISCLAIMER:

E-consults are based on the clinical data available to the reviewing provider, and are furnished without benefit of a comprehensive evaluation or physical examination. All advice and recommendations must be interpreted in light of any clinical issues, or changes in patient status, not available to the reviewing provider. The ongoing management of clinical problems addressed by the e-consult is the responsibility of the referring provider. If you have further questions or would like clarifications regarding e-consult advice, please contact the reviewing provider. If needed, the patient will be scheduled for an in-office consultation.

All URGENT consultations require provider-to-provider communication. If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.

Please note these guidelines important for ALL referrals:

- **Prior** to referral, ALL patients need visual acuity testing with an eye chart (each eye separately) as well as a detailed history of presenting illness.
- **Prior** to referral (unless urgent), outside records (from outside ED, optometry, or ophthalmology) should be obtained and uploaded under the **Media** Section in Healthlink or faxed to the Ophthalmology Clinic at (408) 885-5849.

Please note the required fields within the referral order:

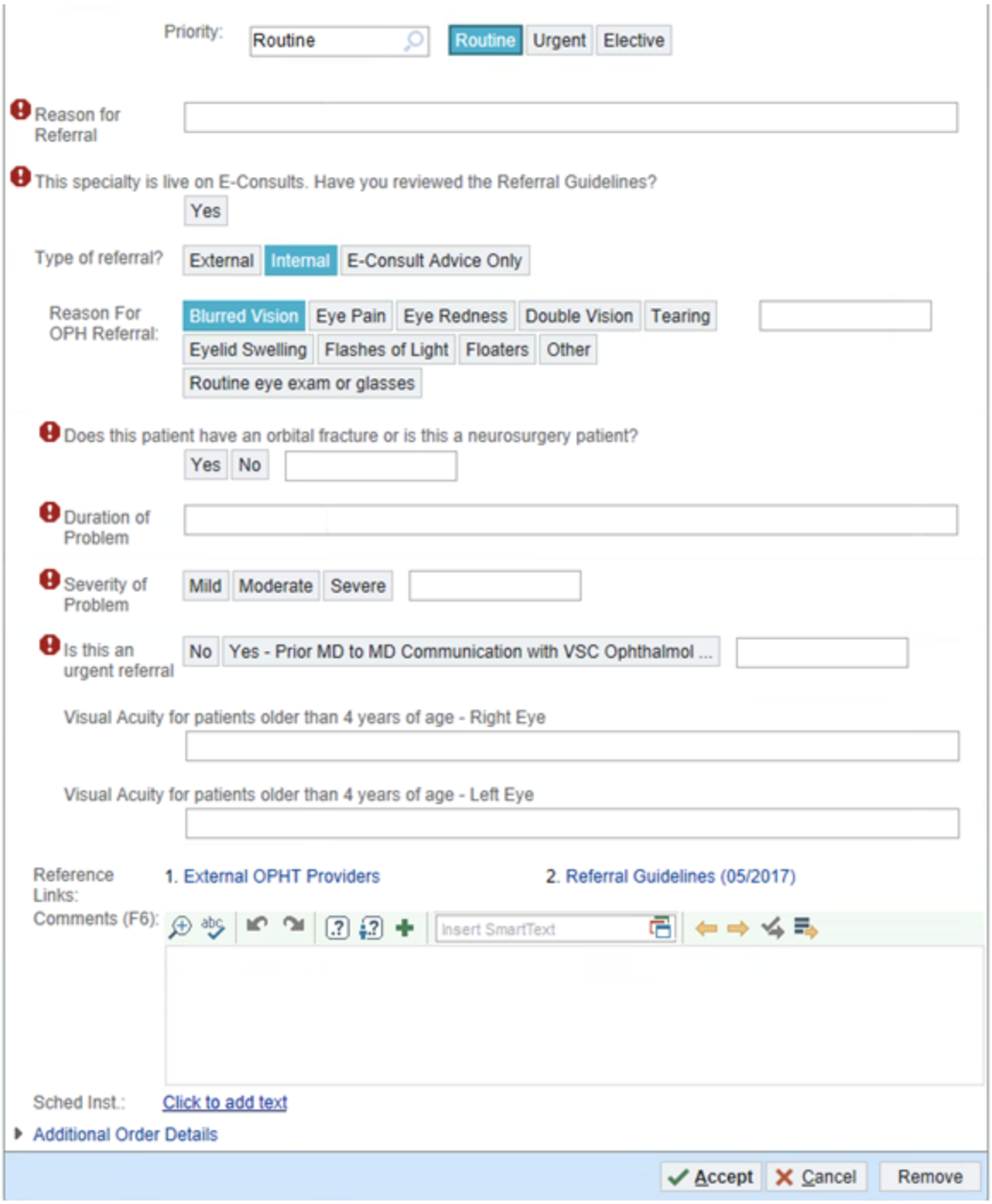
Priority:
Routine
Routine
Urgent
Elective
Reason for Referral
This specialty is live on E-Consults. Have you reviewed the Referral Guidelines?
Yes
Type of referral?
External
Internal
E-Consult Advice Only
Reason For OPH Referral:
Blurred Vision
Eye Pain
Eye Redness
Double Vision
Tearing
Eyelid Swelling
Flashes of Light
Floaters
Other
Routine eye exam or glasses
Does this patient have an orbital fracture or is this a neurosurgery patient?
Yes
No
Duration of Problem
Severity of Problem
Mild
Moderate
Severe
Is this an urgent referral
No
Yes - Prior MD to MD Communication with VSC Ophthalmol ...
Visual Acuity for patients older than 4 years of age - Right Eye
Visual Acuity for patients older than 4 years of age - Left Eye
Reference Links:
1. External OPHT Providers
2. Referral Guidelines (05/2017)
Comments (F6):
Insert SmartText
Sched Inst.:
Click to add text
Additional Order Details
Accept
Cancel
Remove

Table of Contents

BLURRED VISION

1. **Background**
    a. Refractive errors are the most common vision problems, more commonly known as near-sightedness, far-sightedness, and presbyopia
    b. Presbyopia is an age-related condition (common over the age of 40) in which the ability to focus up close becomes more difficult
    c. Cataract, or the clouding of the lens in the eye related to aging, is also a common cause of blurry vision
    d. Patient information/NEI websites:
        i. https://nei.nih.gov/healthyeyes/problems
        ii. https://nei.nih.gov/health/cataract/cataract_facts
        iii. https://nei.nih.gov/health/errors/presbyopia

2. **Pre-referral evaluation and treatment**
    a. Evaluation
        i. Determine if blurred vision is acute or chronic
        ii. Check vision to determine severity of blurriness
        iii. Identify if symptoms are due to refractive error alone and can be resolved with spectacle correction
    b. Management
        i. All patients with non-acute blurred vision need to first be evaluated for glasses by an optometrist.

3. **Indications for referral**
    a. URGENT referral
        i. Identify acute and severe vision loss. Acute vision loss: MD to MD triage
    b. Routine referral
        i. If vision is not corrected to patient satisfaction with glasses after optometry evaluation, then place routine referral to Eye Clinic for evaluation

CHALAZION

1. **Background**
    a. A chalazion is an engorged tear gland in the eyelid. It is typically a smooth painless subcutaneous nodule
    b. A patient may have a single or multiple chalazia
    c. These are more common in children but may occur at any age
    d. Patient information website:
        i. http://www.geteyesmart.org/eyesmart/diseases/chalazion-stye/index.cfm

2. **Pre-referral evaluation and treatment**
    a. Evaluation
        i. Determine if inflammation if present or absent
            1. Inflammation is characterized by redness, tenderness or discharge
    b. Management
        i. Most chalazia can be managed medically and do not need drainage
        ii. Chalazion without inflammation:
            1. Soak a washcloth with hot but not burning water. Press it firmly against the closed eyelids for one minute.
            2. Do this 4 times a day for one month.
            3. If discharge begins to come out of the eyelid do the hot compresses every 2 hours until the chalazion is gone.
            4. If no improvement after one month add oral erythromycin 12.5mg/kg/day in bid dosing with meals in children. Adults need to take 1 tablespoon of flaxseed oil or one capsule every day for 6 weeks.
        iii. Chalazion with inflammation:
            1. Hot compresses as above.
            2. If appears to be a preseptal cellulitis treat as for any preseptal cellulitis.
            3. If localized redness start flaxseed oil in adults and oral erythromycin in children with hot compresses 4 times a day.

3. **Indications for referral**
    a. URGENT referral and page on-call resident listed on AMION:
        i. **Pain with sunlight or photophobia** indicates the inflammation has spread to the cornea. This needs to be seen promptly in the eye clinic.
        ii. An **adult over 50 years of age with a chalazion that does not respond to hot compresses and flaxseed oil over a 3 month period** will need to be evaluated in the eye clinic.

DIABETES

1. **Background**
    a. Diabetic eye disease may include diabetic retinopathy, cataract, and glaucoma
    b. Diabetic retinopathy is caused by changes in the blood vessels of the retina.

c. In some people with diabetic retinopathy, blood vessels may swell and leak fluid. In other people, abnormal new blood vessels grow on the surface of the retina.
d. Patient information websites:
    i. NEI website:
        1. https://nei.nih.gov/health/diabetic/retinopathy
    ii. AAO website:
        1. http://eyewiki.aao.org/Diabetic_Retinopathy

2. Pre-referral evaluation and treatment

a. Evaluation
    i. All diabetics should be screened on a yearly basis
        1. **All asymptomatic patients needing routine screening**
            a. **Enter referral to Endocrine clinic for non-mydriatic photos (read and interpreted by ophtho MD or optometry)**
        2. Patients without diabetic retinopathy can be followed with non-mydriatic photos in Endocrine clinic
b. Management
    i. Establish PCP
        1. Strict control of blood sugars and other systemic diseases (blood pressure, cholesterol, etc) is the mainstay of treatment
        2. All patients need to have PCP prior to referral to the eye clinic as systemic control is paramount to treatment of diabetic retinopathy
    ii. Refer to diabetic education clinic

3. Indications for referral

a. URGENT referral
    i. **Acute / severe vision loss**: may be due to vitreous hemorrhage, tractional retinal detachment, or retinal vein occlusion -> visual acuity testing with eye chart.
        1. If vision is severely impaired, **MD to MD triage; please page on-call resident listed on AMION**
b. Routine referral
    i. **Patients with proliferative diabetic retinopathy or macular edema** may need local treatment in conjunction of systemic therapy

EYE PAIN

1. Background

a. The eye is often a location of referred pain from other sources in the head and neck
b. The nature of the pain experienced can often direct one to the source
c. Glaucoma, or elevated intraocular pressure, is not associated with ocular pain except in those cases in which the pressure is acutely elevated to a very high level in the case of angle-closure glaucoma. This is usually associated with rather severe pain, often nausea, and decreased vision.
d. Patient information websites
    i. http://www.geteyesmart.org/eyesmart/diseases/dry-eye/index.cfm
    ii. http://www.geteyesmart.org/eyesmart/diseases/blepharitis.cfm
    iii. http://www.geteyesmart.org/eyesmart/diseases/corneal-abrasion.cfm

2. Pre-referral evaluation and treatment

a. Evaluation and Management
    i. Determine nature of pain and any associated symptoms that can help identify source of eye pain
        1. **Foreign body or "sandy" type discomfort** of mild to moderate level:
            a. Often the result of dry eyes
            b. These are treated with frequent (4-6 times a day) use of artificial tears during the day and lubricant ointments qhs for night time comfort. The goal is not always to eradicate the discomfort but to reduce it to a tolerable level
        2. **Pain similar to foreign body sensation accompanied by symptoms of ocular itching**:
            a. Often associated with an allergic component
            b. Along with tears, can add an ocular antihistamine agent such as zaditor BID on an ongoing basis
        3. **Episodic, brief (seconds) and infrequent sharp pain**:
            a. Due to ocular surface irritation from environmental factors
            b. Also managed with artificial tears
        4. **Retro-orbital and radiating pain**:
            a. Seldom due to an ocular etiology

b. Evaluation should be directed to other likely source such as sinuses, cervical spine for a muscular/skeletal basis or intracranial sources

5. **True photophobia**, as opposed to an aversion to brightly or fluorescent lighted environment manifest by a level of discomfort, is a symptom associated with distinct eye pain felt in the eye when a bright light is directed at the eye or normal room lights are dimmed
    a. This may be due to corneal disease or intraocular inflammation
    b. Should be referred urgently

3. **Indications for referral**
    a. URGENT referral with MD to MD triage; please page the on-call resident listed on AMION
        i. **True photophobia** as detailed above
        ii. **Severe eye pain associated with decreased vision**

FLOATERS

1. **Background**
    a. Small specks or clouds moving in vision, may be more noticeable when looking at plain background like a blank wall or blue sky
    b. Floaters are tiny clumps of cells or material inside the vitreous
    c. Floaters may be due to vitreous syneresis, posterior vitreous detachment, or most concerning, a retinal tear or detachment
    d. Floaters may also be symptoms of vitreous hemorrhage due to diabetes
    e. Patient information website:
        i. http://www.geteyesmart.org/eyesmart/diseases/floaters-flashes/index.cfm

2. **Pre-referral evaluation and treatment**
    a. Evaluation
        i. Determine which patients need to be seen urgently for a possible retinal tear or detachment
            1. Determine if floaters are acute or chronic
            2. Determine if there are associated flashes or curtain/shadow in the peripheral vision
            3. Is the patient a diabetic with a known history or proliferative diabetic retinopathy?
    b. Management
        i. Referral to eye clinic for dilated fundus examination.

ii. Determine if this can be routine or urgent (see below)

3. **Indications for referral**
    a. URGENT referral with MD to MD triage; please page the on-call resident listed on AMION
        i. Sudden increase in size or number of floaters
        ii. Flashes of light
        iii. Curtain/shadow in vision

GLAUCOMA

1. **Background**
    a. Glaucoma is one of the leading causes of blindness in the US.
    b. The problem ultimately affects the optic nerve, causing damage, and results in irreversible vision loss.
    c. Anyone can develop glaucoma but it tends to occur in certain patient populations.
    d. Patient information
        i. https://nei.nih.gov/glaucoma

2. **Pre-referral evaluation and treatment**
    a. Management
        i. Symptom review
            1. Has the patient ever been told he/she has glaucoma?
            2. Is there a family history of glaucoma?
            3. Is the patient of African American descent, age over 40 or is Hispanic over 60 years of age
            4. Is the patient over 60 years of age

3. **Indications for referral**
    a. Urgent referral to eye clinic
        i. If patient complains of symptoms: severe pain, redness, decreased vision
    b. Glaucoma referral
        i. If the answer to any symptom review question is “yes”
            1. Refer for complete eye exam

MACULAR DEGENERATION

1. **Background**
    a. Leading cause of vision loss among people age 50 and older

b. Causes damage to the macula, the central part of the retina needed for sharp, central vision
c. Risk factors: age, smoking, race (more common in Caucasians than African-Americans or Hispanics/Latinos), and family history/genetics
d. Patient information website:
    i. NEI website: https://nei.nih.gov/health/maculardegen/armd_facts

2. Pre-referral evaluation and treatment

a. Evaluation
    i. Determine if patient has family history of macular degeneration
    ii. Determine if patient has prior diagnosis of macular degeneration
    iii. Determine if patient has any symptoms
    iv. Determine if patient has central scotoma or distortion of central vision
b. Management
    i. Lifestyle changes
        1. Counsel all patients on smoking cessation
        2. Maintain normal blood pressure and cholesterol levels
        3. Encourage healthy diet rich in green, leafy vegetables and fish; do not routinely recommend AREDs vitamins unless directed by an ophthalmologist
    ii. Referrals as indicated below

3. Indications for referral

a. URGENT referral with MD to MD triage; please page the on-call resident listed on AMION
    i. Symptomatic patients: New onset central scotoma, distorted central vision, or severe painless vision loss
b. Routine referral
    i. Asymptomatic patients with known diagnosis of macular degeneration or positive findings by an outside optometrist should have routine referral to ophthalmology for evaluation
c. Asymptomatic patients with family history of macular degeneration should be evaluated by optometrist (internal or external) and referred to the eye clinic only if there are positive findings

RED EYE

1. Background

a. The differential diagnosis for the red eye can be long and extensive. Common causes include:

i. Allergy
ii. Infection (viral or bacterial)
iii. Dry eye
iv. Uveitis
v. Glaucoma

b. Patient information website: http://www.geteyesmart.org/eyesmart

2. Pre-referral evaluation and treatment

a. Evaluation and Management
   i. Identify associative symptoms and triage accordingly
      1. Itching: Treat with cold compresses and chilled artificial tears
      2. Yellow discharge: Treat with broad spectrum antibiotic drops for 1 week
      3. Colorless discharge: Treat with cold compresses, artificial tears and hand hygiene (to limit spread to fellow eye or family members). Most commonly viral conjunctivitis, especially if associated with cold/fever.
      4. Foreign body sensation: most commonly due to dry eyes. Treat with warm compresses and artificial tears
      5. Light sensitivity and blurred vision: see below
      6. Irregular pupil: see below
   ii. Check vision

3. Indications for referral

a. URGENT referral with MD to MD triage; please page the on-call resident listed on AMION
   i. Light sensitivity, blurred vision, irregular pupil

Revisions:

- January 2017, formatting
- June 2017, content
- October 2017, formatting