MANCHESTER ROYAL EYE HOSPITAL AND MANCHESTER LOCAL OPTOMETRIC COMMITTEE

REFINING GLAUCOMA REFERRALS BY ACCREDITED OPTOMETRISTS
PRACTICE PROCEDURES

The new referral protocol **will only be applicable** if the patients G.P. is registered in the Manchester Health Authority Area, and it is essential that the receptionist ascertains this before booking the appointment (see enclosed register of Manchester General Practitioners).

The patient arrives at or contacts an accredited optometrists practice after having been referred to them either by another non-accredited optometrist or by their G.P. or by direct referral from the Manchester Royal Eye Hospital.

Please note that an optometrist outside the Manchester Health Authority area who examines a patient whose G.P is registered in Manchester will have his glaucoma referral redirected to a Manchester accredited optometrist for the first assessment.

Receptionist should ensure that when a patient is referred through this pathway they make an appointment only with the accredited optometrist and of a duration of long enough for the protocol procedures to be carried out. The receptionist should advise the patient that drops are likely to be needed and that the examination may take longer, also warning the patient that the drops may blur the vision for a few hours making driving difficult or impossible. It may be in fact advisable for the patient to bring sunspecs with them.

When the patient is referred by a non-accredited optometrist ensure that the patient has a completed G.O.S. 18 and take it from them as soon as possible for the accredited optometrist to peruse before the appointment..
After the examination the glaucoma referral form should be completed **LEGIBLY** and in full and distributed according to the protocol,(**having had the patient sign to give permission for the distribution)**

Following the examination the patients should be advised of the result of the examination and be told as to whether the accredited optometrist agrees with the need for glaucoma referral or whether in their opinion there is no need to be seen by the eye hospital.

The accredited optometrists report will be sent out as follows:

The first (white) copy(in the event of the decision to refer) should be sent to the Manchester Royal Eye Hospital along with the results of the field test in order for an appointment at the eye hospital to be made.
The second (yellow) copy ,(no matter whether the patient is to be referred or not), along with another copy of the field test results will be sent to the ophthalmic payments officer along with a payment claims form. The payments officer will forward it to the appropriate person who is carrying out the clinical audit.
The third (green) copy is to be sent to the patients G.P. for their information as to what action has been taken with regard the suspect glaucoma patient .
The fourth (pink) copy is to be sent to the referring optometrist to inform them of the results of the second opinion by the accredited optometrist and actions taken.

MANCHESTER ROYAL EYE HOSPITAL AND MANCHESTER LOCAL OPTOMETRIC COMMITTEE

SCHEME FOR REFINING GLAUCOMA REFERRALS BY ACCREDITED OPTOMETRISTS

Criteria and Mechanism for Payment

1. The new protocol is to help ensure that all suspect glaucoma patients receive the equivalent of the first eye hospital visit in the community. One of the benefits of the protocol will be a reduction in the number of false referrals to the eye hospital. Only accredited optometrists who have attended the Manchester Royal Eye Hospital course and agree to attend the continuing accreditations are eligible for payment. The accredited optometrist will sign a contract with the Health authority to provide the service and will be indemnified by the A.O.P. professional indemnity scheme (Non A.O.P. members need to contact the individual indemnity providers).
   NB. Please note that failure to follow the protocol or attend further accreditation courses could lead to the removal from the accredited list.
2. Please note that it is the individual optometrist who is accredited and not the practice. Also note that it is the optometrist's responsibility to establish the patient’s eligibility for screening before claiming the fee.
3. A patient will be eligible, and the additional fee payable by Manchester Health Authority only if the patient's General Practitioner is on the Manchester Register.

MANCHESTER ROYAL EYE HOSPITAL AND MANCHESTER LOCAL OPTOMETRIC COMMITTEE

SCHEME FOR REFINING GLAUCOMA REFERRALS BY ACCREDITED OPTOMETRISTS

Referral Protocol for Glaucoma Suspects

Any patient referred to an accredited optometrist under the Manchester Royal Eye hospital scheme will undergo the following examinations (in the order below) and the assessment form will be completed.

1) The current spectacle prescription will be noted on form and corrected visual acuity will be checked and recorded.
2) The patient will undergo a suprathreshold visual field test with a Humphrey, Henson or Dicon machine ***before*** disc assessment.
3) The anterior chamber depth will be measured and graded by Van Herrick's method (narrow angles would obviously have IOP's measured again after dilation),and any anterior chamber abnormalities(e.g. rubeosis, pseudoexfoliation) will be noted.
4) The patient will have their intra ocular pressures measured ***before*** dilation by either Goldmann or Perkins Tonometry.
5) The patient will be dilated and disc assessment made with a Volk lens with special note being made with regard :-
   a) Size of disc.
   b) Vertical CD ratio.
   c) Cup type (horizontally oval, vertically oval or round).
   d) Observation on ISNT rule being broken or not (stating location of abnormality.
   e) Any presence of peri-pappillary atrophy stating location.
   f) Any bowing back with NRR unclear or the appearance of any focal notches or disc haemorrhages stating location.
   g) Any vascular signs (bayoneting, vessel narrowing, circumlinear vessel bearing nasalisation, flyover vessels, collateral vessels.

The patients form will be filled in and will then be assessed and classed as either no glaucoma, ocular hypertensive, positive glaucoma or found to be suspicious of having glaucoma. In the event of suspicion of or positive recognition of glaucoma the patient will be referred directly to the Manchester Royal Eye Hospital Appointments using the report form and enclosing visual field results (including any repeat fields) .

In the event that the accredited optometrist decides not to send the patient to the eye-hospital but refer the patient back to the original referring optometrist then a suggested review date (normally twelve months, but possibly sooner for young patients) will be put on the report and posted back to the original optometrist.

The protocol for referral will be:-

1. **Intraocular pressure alone** (i.e. normal fields and disc appearance)
   IOP 26 mm Hg or greater on two occasions by applanation Tonometry NB 35 mm Hg or more merits urgent referral .
2. **Visual Field alone** (i.e. normal IOP and optic disc appearance)
   Consistent on two occasions
   NB Check if explained by other optic disc or retinal pathology and refer as such.
3. **Optic Disc appearance alone** (i.e. Normal IOP and fields) Pathological cupping must be unequivocal by stereoscopic examination as per protocol above or there should be asymmetry of 0.2 or greater.
4. **IOP and Optic Disc indications**
   Raised IOP of 22mmHg or greater along with suspicious optic disc or cup asymmetry of 0.2 or greater.
5. **Optic Disc and Visual Field**
   If both show definite glaucomatous change IOP is “irrelevant" if disc and field changes fit. (If unsure repeat IOP and field).
6. **Change in Optic Disc**
   Documented change in disc appearance, (i.e. cup size , neuroretinal rim configuration, new haemorrhage or change in C/D ratio of 0.2 or greater).
7. **Secondary Glaucoma**
   If anterior segment signs of secondary glaucoma ***plus*** IOP's of 22 mmHg or greater on two occasions. N.B. Treat Pseudoexfoliation as POAG but review annually if raised IOP.
8. **Narrow Angle**
   If suspect narrow angle refer if symptoms of subacute attacks or IOP's of 22 mmHg or greater (Van Herrick grade 2 or less).

9. **Unusual Problem**
   E.g. Young patient (under 40) and suspect developmental or secondary or early onset glaucoma. **PHONE OR FAX FOR ADVICE** (as may require referral outside criteria).

MANCHESTER GLAUCOMA REFERRAL ASSESSMENT SCHEME CLAIM FORM

Date...................

Name of Practitioner..

Practice address for payment ....
....
....
....

PATIENT DETAILS

SURNAME .... FIRST NAME................................

ADDRESS .... DATE OF BIRTH............................

Post Code ....

MANCHESTER HEALTH AUTHORITY GENERAL PRACTITIONERS NAME AND ADDRESS

....
....
....
....

I have today performed an assessment of a suspect glaucoma patient. I have carried out all the tests in the protocol and completed the assessment report form and taken the appropriate action. I am an accredited optometrist and wish to claim the Glaucoma Assessment Fee.

Signed..Health Authority List Number..................

Copy for Eye Hospital Referral

MANCHESTER GLAUCOMA REFERRAL REFINEMENT SCHEME

NHS NO.

PATIENT Date of Birth ____/____/____

Surname ______________ First Name ______________

Address ______________________________

____

Post Code __________ Phone No. __________

ASSESSOR Date of Assessment ____/____/____

Name ______________________________

____

____

GP Name & Address ______________________________

____

Prescription details from current sight test Date:

	Uncorrected V	Sph	Cyl	Axis	Prism	Base	VA	Add	Near VA
RE									
LE									

Previous corrected Visual Acuity Date

Ⓡ 6/

Ⓛ 6/

Risk Factors: Family History ☐ Diabetes ☐ Myopia ☐ Hypertensive ☐ Afro Carribean ☐

CURRENT OPHTHALMIC STATUS		RIGHT EYE		LEFT EYE	
VISUAL FIELDS (enclose all copies) Comment on reliability Good / Bad		**Normal / Abnormal / Suspect**		**Normal / Abnormal / Suspect**	
INTRA OCULAR PRESSURES mmHg					
ANGLE (VAN HERRICK GRADE)					
ANTERIOR CHAMBER OBSERVATION eg.	PSEUDOEXFOLIATION RUBEOSIS	**YES / NO** **YES / NO**		**YES / NO** **YES / NO**	
OPTIC DISC Please draw appearance and features in space provided	**DISC SIZE**	**L / M / S**	◯	**L / M / S**	◯
	C/D RATIO				
	CUP SHAPE	**VO / HO / R**		**VO / HO / R**	
ISNT RULE BROKEN		**YES / NO Location?**		**YES / NO Location?**	
PERI - PAPILLARY ATROPHY		**YES / NO Location?**		**YES / NO Location?**	
DISC SIGNS	FOCAL NOTCH BOWED BACK	**YES / NO Location?** .... **YES / NO Location?**		**YES / NO Location?** .... **YES / NO Location?**	
VASCULAR SIGNS (Bayonet / Nasalisation / Vessel Bearing etc.					
STATUS OF EYE		NORMAL / OHT / GLAUCOMA / SUSPECT		NORMAL / OHT / GLAUCOMA / SUSPECT	
ACTION TAKEN By accredited Optometrist (GP copy for information only)		1. The above patient is a suspect glaucoma patient and requires an eye hospital appointment urgently / soon ☐		2. The above patient is thought not to have glaucoma and should be reviewed by original referring optometrist in .... months ☐	

Signature of Accredited Optometrist

Signed ....

I agree / do not agree that any Ophthalmologist to whom I am referred for medical consultation and / or treatment may make information relevant to my eye condition and its treatment available to my Optometrist / Ophthalmic Medical Practitioner.

Signed .... Date ....

Version 17.10.00