RANZCO Triage Guidelines

Speciality	Time Sensitive (see < 3 months of initial or planned appointment)		Defer Appointment (by 4-12 months)
	High Urgency (Will usually require clinic visit)	Medium Urgency (Where appropriate, consult via telehealth)	Low-Urgency (Where appropriate, consult via telehealth)
General Ophthalmology			
New/Follow-up	**ANY ACUTE SEVERE VISUAL LOSS**		Blepharitis
			Mild/moderate dry eye
			Watery eye
			Most conjunctivitis (triage via telehealth)
Surgery			**ELECTIVE CATARACT SURGERY**, YAG Capsulotomy, Refractive laser surgery
Cataract			
New/Follow-up			Cataract/PCO reviews
Surgery	Cataract surgery for intractable high IOP (phacomorphic, phacolytic glaucoma, angle closure)	Cataract surgery for cataract blindness when the patient is legally blind (i.e. combined effect of BCVA <6/60 in both eyes or field of vision constricted to 10 degrees or less of arc around central fixation in the better eye)	**ELECTIVE CATARACT SURGERY**, YAG capsulotomy
Cornea/Refractive			
New/Follow-up	Microbial keratitis	Minor trauma (eg abrasions, foreign bodies, recurrent erosion syndrome)	Blepharitis
	Corneal trauma	Corneal ectasia with moderate risk of progression (age <21 or documented progression >1D in 6 months)	Mild/moderate dry eye.other ocular surface condition
	Acute Peripheral Ulcerative Keratitis	OSSN	Corneal ectasia with low risk of progression
	Neurotrophic cornea with ulceration	Marginal Keratitis (follow-up with telehealth if appropriate)	Drug induced keratopathies
	Therapeutic (bandage) contact lens patients	Severe sight-threatening ocular surface disease	Metabolic keratopathies
	Corneal graft rejection	Routine post-operative patients	
Surgery	Urgent tectonic keratoplasty (perforations)	Keratoplasty for bullous keratopathy with high risk of infection or pain	Laser refractive surgery
		Keratoplasty in patient <6/60 in both eyes with expected short term improvement	Routine corneal transplantation
		Cross linking for progressive ectasia (either rapid progression or borderline thickness)	Pterygium surgery
			Collagen cross-linking for slowly progressive ectasia
Glaucoma			
New/Follow-up	IOP>40mmHg	After change of glaucoma therapy where IOP is anticipated to change	Stable glaucoma monitoring with no documented progression for 2 years
	Acute angle closure	Routine post-operative care for glaucoma filtration surgery/tubes	Ocular hypertension with no evidence of glaucoma and at low risk of developing glaucoma in the next 6 months
	Acute neovascular glaucoma	New referral optometrist diagnosed glaucoma early/moderate/advanced according to RANZCO referral pathway for glaucoma management	Optometrist referred glauocma suspect with low suspicion of disease (as per RANZCO Referral Pathway)
	Acute uveitic glaucoma	Optometrist referred glaucoma suspect with high suspicion of idsease (as per RANZCO Referral Pathway) where optometrist and ophthalmologist consider urgency is medium	Optometrist referred glauocma suspect with high suspicion of disease (as per RANZCO Referral Pathway) not considered medium urgency by the ophthalmologist
	Acute lens related glaucoma	Anyone with IOP>30 and glaucomatous visual field defect	
	New referral that referr and ophthalmologist consider urgent	Uncontrolled glaucoma	
Surgery	Lens extraction surgery to ameliorate angle closure disease not controlled with laser or medical therapies	Lens extraction surgery to ameliorate angle closure disease when risk of progression of angle closure or glaucoma over the next 6 months is unacceptably high. This includes the at-risk fellow eye of eyes blinded by angle closure disease	Elective cataract surgery in glaucoma patient not blinded by cataract
	Glaucoma surgery for IOP lowering of any type in advanced glaucoma, rapid progression or very high IOP where clinically important progression I slikely in the next 1 month, where conservative therapies have failed, are likely to fail, or are contraindicated.	Glaucoma surgery for IOP lowering of any type in glaucoma here clinically important progression is likely in the next 9 months, where conservatibe therapies have failed, are likely to fail, or are contraindicated.	Any lens extraction procedure combined with microbypass glaucoma surgery where the lens extraction itself does not fall into high or medium urgency
	Any surgery to manage acute sight treatening complication of glaucoma surgery (e.g. bleb or tube infection)		
Medical Retina			
New/Follow-up	Suspected or confirmed CNV needing treatment	Macular oedema requiring treatment	Non-neovascular (dry) AMD
	Intravitreal injections for: Neovascular AMD, Diabetic macular oedema, Retinal vein occlusion, other CNV, macular oedema. **Treat and extend to maximum interval possible**		Low-risk diabetic retinopathy screening
	Active proliferative diabetic retinopathy requiring treatment (PRP laser or intravitreal-antiVEGF)		Non-proliferative diabetic retinopathy without macular oedema
	Malignant hypertensive retinopathy		Stable treated proliferative diabetic retinopathy
			Central serous chorioretinopathy
			Macular telangiectasia without CNV
			Retinal Dystrophies
			Screening for macular toxicity (e.g. plaquenil)
			Angioid streaks
			Hypertensive retinopathy (non-malignant)
			Choroidal folds
Vitreoretinal Surgery/Trauma			
New/Follow-up	Acute retinal detachment	Acute full thickness macular holes	Epiretinal membranes
	Suspected retinal tears	Severe vitreomacular traction syndrome	Silicone oil removal (unless developing complications such as emulsification)
	Open globe injuries: Including PEI, IOFB	Myoptic traction maculopathy with foveal detachment	Intraocular lens procedures
	Acute endophthalmitis	Heavy liquid, densiron removal	Symptomatic vitreous opacities
	Vitreous haemorrhage (dense, requiring vitrectomy)	Exposed scleral buckles at risk of infection	
	Dropped nucleus requiring vitrectomy/lensectomy		
	Submacular haemorrhage requiring vitrectomy		
	Aqueous misdirection requiring vitrectomy		
	Complex Surgery post-ops (minimise visits)		
	Diagnostic vitrectomy for infectious or oncological causes	Most routine post ops (minimise visits)	
Surgery	Surgery for the above	Surgery for the above	Surgery for the above

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THE LEADERS IN COLLABORATIVE EYE CARE

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Speciality	Time Sensitive (see < 3 months of initial or planned appointment)		Defer Appointment (by 4-12 months)
	High Urgency (Will usually require clinic visit)	Medium Urgency (Where appropriate, consult via telehealth)	Low-Urgency (Where appropriate, consult via telehealth)
Uveitis			
New/Follow-up	Panuveitis	New cases of Acute Anterior Uveitis should be given a standard 6-8 week tapering course of drops and review (or telephone consult) at 4-6weeks. Clinic review in 3 months if indicated by telephone consult at that time point.	Patients with an established history of recurrent, self limiting episodes of AAU without sight threatening complications (e.g. CMO, steroid response) could be considered for telephone consult at the onset of a recurrence and for follow-up at 6-8 weeks, with clinical review if indicated
	Posterior Uveitis	Chronic/persistent anterior uveitis managed with topical therapy only, telehealth recommended where possible	Uveitis cases in remission (=quiescence without ANY treatment)
	Intermediate Uveitis with vision threatening complications	Quiescent/stable forms of uveitis on stable systemic therapy (prednisolone dose <=7.5mg/daily); telehealth recommended where possible	
	Retinal vasculitis	It is highly recommended that patients receiving an intravitreal depot steroid injection for uveitis have at least 1 clinic review/in person IOP check (ophthalmologist or optometrist) 3-6 weeks post-injection	
	Patients with uveitis of any form affecting an only eye (VA in fellow eye <6/60)		
Surgery	Vitreous biopsy and/or AC tap for infectious/inflammatory uveitis		Most uveitic cataracts
Ocular Oncology			
New/Follow-up	Suspected malignant ocular tumours (e.g. ocular melanoma, metastases, intraocular lymphoma)	Fundus tumours causing macular exudation (choroidal haemangioma, Coats, retinal capillary haemangioblastoma)	Stable choroidal naevi, CHRPE, iris cysts
	Confirmed malignant ocular tumours requiring acute treatment	Tumours previously booked for up to 6 months planned follow-up interval	Stable treated tumours
	Tumours previously booked for 3 month planned follow-up interval		Tumours previously booked for over 6 months planned follow-up interval
Surgery	Surgery for malignant tumours (including plaque brachytherapy for choroidal melanoma)	Surgery for the above	
Oculoplastics			
ALERT: DUE TO THE HIGH RISK OF COVID-19 INFECTION FROM THE NASOPHARYNX, AVOID ALL NASAL SYRINGING, LACRIMAL SURGERY AND NASAL ENDOSCOPY. TREAT THYROID			
New/Follow-up	Severe thyroid eye disease	*Progressive* benign orbital tumours	Orbit: all other, including TED (stable mild-moderate)
	Orbital tumours (sight-threatening or malignant-suspected/known)	Moderately-severe thyoid eye disease	Other eyelid malpositions: ptosis, brow ptosis, dermatochalasis, ectropion
	Orbit: Vascular (CCF, progressive/sight-threatening vascular anomalies- e.g. extensive haemangioma, progressive vascular malformation e.g. acute bleed)	Entropion (triage with telehealth if appropriate)	Some low-risk BCC that has previously been examined (triage w ith telehealth if appropriate)
	Orbital inflammatory disease (orbital/periorbital cellulitis, orbital abscess; sight-threatening orbital inflammation of any cause; acute dacryocystitis/sac abscess)	BCC (triage with telehealth if appropriate)	Benign periocular tumours (e.g. chalazion/papilloma)
	Periocular malignancy (biopsy proven or suspected) including melanoma (invasivs & in situ), sebaceous carinoma, SCC, other high grade malignancy (Merkel cell, adenexal carcinoma etc.), high risk BCC (medical or lateral canthal, recurrent, high risk subtype, locally advanced i.e. orbital invasion)	Lacrimal: Recurrent/low grade dacryocystitis, canaliculitis. Treat medically first, if requires surgery prefer percutaneous drainage, avoid DCR due to COVID-19 risk	Lacrimal: All other
	Post-operative complex surgery	Post-operative simple surgery	
	Recent trauma including eyelid and canalicular lacerations, orbital fractures and suspected orbital foreign body	Paediatric ptosis with known/high risk of amblyopia (visual deprivation, failed amblyopia therapy)	
	Dacryocystocele (paediatric CNLDO with nasal involvement not resolving/acutely infected). Treat medically first, if requires surgery prefer percutaneous drainage, avoid DCR due to COVID-19 risk		
Surgery	Surgery for the above	Surgery for the above	Surgery for the above
Genetics			
New/Follow-up			Most patients
Paediatrics			
New/Follow-up	Sight or potential life (systemic) threatening conditions	Patients having amblyopia treatment. Where possible, use telehealth	Case by Case triage
	Cataracts causing amblyopia or under 4 months old	Paediatric oculoplastic/adnexal cases	
	Reduced vision in both eyes	Reduced vision in one eye over age 7. Where possible, use telehealth video/photos to triage	
	Reduced vision in one eye under age 7	Examination under anaesthesia where management is time-sensitive	
	Post-ops within last 2 months		
	ROP screening		
	Children on medication (drops or systemic) for glaucoma, uveitis, corneal disease		
Surgery	Cataract surgery in under 4 month olds or where causing amblyopia		Strabismus surgery
Strabismus			
New/Follow-up	Triage of referrals on case by case basis (accept suspected neurological strabismus)	Triage of referrals on case by case basis (accept strabismus where amblyopia management is also required). Where possible, use telehealth video/photos	Most other non-acute strabismus cases
Surgery	Acute trauma related requiring surgery		Most strabismus surgery and botulinum muscle injections
Neuro-Ophthalmology			
New/Follow-up	Patient by patient triage needed (accept acute optic neuropathies, suspected SOL or raised intracranial pressure, neurological diplopia, acute pupillary abnormalities)	Where possible, use telehealth video/photos	Stable patients or patients where management will not change outcomes
Surgery	Optic nerve sheath fenestration for severe visual loss in IIH		

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