

# OPHTHALMOLOGY PRIORITY CRITERIA TOOL

July 2008

|   |  |
|---|--|
| Patient Name: _____   | HSN: _____   |
| Patient Date of Birth _____<br>MM DD YYYY   | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| This Form Completed By:<br>Surgeon _____<br>Other Clinician _____<br>Office Staff _____ |  |
| Does your patient want a confirmation letter? If NO check here <input type="checkbox"/> |  |

**Please check the box that most accurately describes the patient's current situation.**

| <b>All Patient Questions 1 to 4</b> | <p>1) Score as proven or suspected cancer <b>only</b> if the patient is being treated for a malignancy or if clinical features and investigations include malignancy in differential diagnosis. Please check the box that most accurately describes the patient's current situation:</p> <p><input type="checkbox"/> Patient with proven or suspected invasive cancer.<br/>Priority 1 - 95% of surgeries to be performed within 3 weeks.</p> <p><input type="checkbox"/> Patient with proven or suspected indolent cancer.<br/>Priority 3 - 90% of surgeries to be performed within 3 months.</p> <p><input type="checkbox"/> Patient requires a routine screening or follow-up procedure for cancer detection.<br/>A scheduled procedure to be performed within 12 months.</p> <p>2) Extent of impairment in visual function (e.g. reading, recognizing faces, seeing steps/curbs, watching TV, driving/reading traffic signs):<br/>0 <input type="checkbox"/> None      3 <input type="checkbox"/> Mild      12 <input type="checkbox"/> Moderate      23 <input type="checkbox"/> Severe</p> <p>3) Other substantial disability (e.g. hearing loss, partially reversible dementia):<br/>0 <input type="checkbox"/> None/mild      4 <input type="checkbox"/> Moderate      10 <input type="checkbox"/> Severe      Please specify disability: _____</p> <p>4) Ability to work or study or live independently or care for dependants:<br/>0 <input type="checkbox"/> Not Applicable      10 <input type="checkbox"/> Threatened, but not immediately<br/>0 <input type="checkbox"/> Not threatened or no difficulties      19 <input type="checkbox"/> Immediately threatened or unable<br/>2 <input type="checkbox"/> Not threatened, but more difficult</p>   |  |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
|-------------------------------------|---|--|-------------------------------|--------------------------------|---|-----------------------|--|----------------------------|--------------|---|----------------------------|--------------|---|----------------------------|--------------|--|-----------------------------|---|---|-----------------------------|---------------|---|-----------------------------|----------------------------|--|--|------|------|----------|--------|----------------------------------|----------------------------|-------------------------------|-------------------------------|--------------------------------|-----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>Cataract Questions 5 - 8</b>     | <p>5) This form is being filled out for which eye?:      a) <input type="checkbox"/> Right Eye      b) <input type="checkbox"/> First Eye for Surgery<br/>(<i>Second eye will be given a higher urgency profile</i>)      <input type="checkbox"/> Left Eye      <input type="checkbox"/> Second Eye for Surgery</p> <p>6) Best corrected visual acuity:</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 35%; text-align: center;">Waitlisted Eye</th> <th style="width: 35%; text-align: center;">Other Eye</th> </tr> </thead> <tbody> <tr> <td>0 <input type="checkbox"/></td> <td>6/9 or better (20/30)</td> <td>0 <input type="checkbox"/> 6/9 or better (20/30)</td> </tr> <tr> <td>3 <input type="checkbox"/></td> <td>6/12 (20/40)</td> <td>0 <input type="checkbox"/> 6/12 (20/40)</td> </tr> <tr> <td>5 <input type="checkbox"/></td> <td>6/18 (20/60)</td> <td>9 <input type="checkbox"/> 6/18 (20/60)</td> </tr> <tr> <td>8 <input type="checkbox"/></td> <td>6/24 (20/80)</td> <td>11 <input type="checkbox"/> 6/24 (20/80)</td> </tr> <tr> <td>11 <input type="checkbox"/></td> <td>6/36 (20/120)</td> <td>13 <input type="checkbox"/> 6/36 (20/120)</td> </tr> <tr> <td>11 <input type="checkbox"/></td> <td>6/60 (20/200)</td> <td>15 <input type="checkbox"/> 6/60 (20/200)</td> </tr> <tr> <td>11 <input type="checkbox"/></td> <td>Can count fingers or worse</td> <td>17 <input type="checkbox"/> Can count fingers or worse</td> </tr> </tbody> </table> <p>7) Glare:      0 <input type="checkbox"/> None/Mild (falls to 20/40 – 20/60)<br/>                  9 <input type="checkbox"/> Moderate (falls to 20/60 – 20/100 from 20/40 or better)<br/>                  18 <input type="checkbox"/> Severe (falls to 20/200 or worse from 20/40 or better)</p> <p>8) Ocular Comorbidity (e.g. age related macular degeneration, chronic simple glaucoma):</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%;">None</th> <th style="width: 10%;">Mild</th> <th style="width: 10%;">Moderate</th> <th style="width: 10%;">Severe</th> </tr> </thead> <tbody> <tr> <td>Age-related macular degeneration</td> <td>0 <input type="checkbox"/></td> <td>(-2) <input type="checkbox"/></td> <td>(-6) <input type="checkbox"/></td> <td>(-15) <input type="checkbox"/></td> </tr> <tr> <td>Other forms of ocular comorbidity</td> <td>0 <input type="checkbox"/></td> <td>0 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> </tr> </tbody> </table> <p>If other forms of ocular comorbidity, please list:<br/> <input type="checkbox"/> Diabetic retinopathy      <input type="checkbox"/> Hypertensive retinopathy      <input type="checkbox"/> Chronic simple glaucoma<br/> <input type="checkbox"/> Other retinal disease      <input type="checkbox"/> Other: _____</p> |  | Waitlisted Eye                | Other Eye                      | 0 <input type="checkbox"/>                    | 6/9 or better (20/30) | 0 <input type="checkbox"/> 6/9 or better (20/30) | 3 <input type="checkbox"/> | 6/12 (20/40) | 0 <input type="checkbox"/> 6/12 (20/40) | 5 <input type="checkbox"/> | 6/18 (20/60) | 9 <input type="checkbox"/> 6/18 (20/60) | 8 <input type="checkbox"/> | 6/24 (20/80) | 11 <input type="checkbox"/> 6/24 (20/80) | 11 <input type="checkbox"/> | 6/36 (20/120)                                 | 13 <input type="checkbox"/> 6/36 (20/120) | 11 <input type="checkbox"/> | 6/60 (20/200) | 15 <input type="checkbox"/> 6/60 (20/200) | 11 <input type="checkbox"/> | Can count fingers or worse | 17 <input type="checkbox"/> Can count fingers or worse |  | None | Mild | Moderate | Severe | Age-related macular degeneration | 0 <input type="checkbox"/> | (-2) <input type="checkbox"/> | (-6) <input type="checkbox"/> | (-15) <input type="checkbox"/> | Other forms of ocular comorbidity | 0 <input type="checkbox"/> | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
|                                     | Waitlisted Eye  | Other Eye  |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 0 <input type="checkbox"/>          | 6/9 or better (20/30)   | 0 <input type="checkbox"/> 6/9 or better (20/30)       |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 3 <input type="checkbox"/>          | 6/12 (20/40)  | 0 <input type="checkbox"/> 6/12 (20/40)                |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 5 <input type="checkbox"/>          | 6/18 (20/60)  | 9 <input type="checkbox"/> 6/18 (20/60)                |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 8 <input type="checkbox"/>          | 6/24 (20/80)  | 11 <input type="checkbox"/> 6/24 (20/80)               |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 11 <input type="checkbox"/>         | 6/36 (20/120)   | 13 <input type="checkbox"/> 6/36 (20/120)              |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 11 <input type="checkbox"/>         | 6/60 (20/200)   | 15 <input type="checkbox"/> 6/60 (20/200)              |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 11 <input type="checkbox"/>         | Can count fingers or worse  | 17 <input type="checkbox"/> Can count fingers or worse |                               |                                |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
|                                     | None  | Mild   | Moderate                      | Severe                         |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| Age-related macular degeneration    | 0 <input type="checkbox"/>  | (-2) <input type="checkbox"/>                          | (-6) <input type="checkbox"/> | (-15) <input type="checkbox"/> |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| Other forms of ocular comorbidity   | 0 <input type="checkbox"/>  | 0 <input type="checkbox"/>                             | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>     |   |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| <b>Non-Cataracts 9 &amp; 10</b>     | <p>9) What is the risk of irreversible damage should this patient not receive this surgery in the next 6 months?<br/>0 <input type="checkbox"/> None      10 <input type="checkbox"/> Minimal      20 <input type="checkbox"/> Moderate      30 <input type="checkbox"/> Major</p> <p>10) What is the expected improvement in the patient's quality of life with surgery?<br/>0 <input type="checkbox"/> None      6 <input type="checkbox"/> Minimal      12 <input type="checkbox"/> Moderate      18 <input type="checkbox"/> Major</p> <p>11) All things considered how would you rate the urgency or relative priority of this patient? (Draw a line)</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> <td style="text-align: center;">10</td> </tr> <tr> <td colspan="5" style="text-align: center;">Not urgent at all</td> <td colspan="6" style="text-align: center;">Extremely urgent (just short of an emergency)</td> </tr> </table> <p>12) In your clinical judgment, what should be the maximum acceptable waiting time for this patient?<br/> Number of days: _____ <b>or</b> weeks: _____ <b>or</b> months: _____</p>   | 0  | 1                             | 2                              | 3   | 4                     | 5  | 6                          | 7            | 8                                       | 9                          | 10           | Not urgent at all                       |                            |              |  |                             | Extremely urgent (just short of an emergency) |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| 0                                   | 1   | 2  | 3                             | 4                              | 5   | 6                     | 7  | 8                          | 9            | 10                                      |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |
| Not urgent at all                   |   |  |                               |                                | Extremely urgent (just short of an emergency) |                       |  |                            |              |   |                            |              |   |                            |              |  |                             |   |   |                             |               |   |                             |                            |  |  |      |      |          |        |                                  |                            |                               |                               |                                |                                   |                            |                            |                            |                            |