Referral form

To enable a two-way dialog between general ophthalmologist and uveitis specialist

REACH
REFER, ESCALATE & ACHIEVE IN NIU

To be completed by general ophthalmologist

Patient name	

Referring physician details

Name	
Address	
Email	
Phone number	
Signature	
Referral date	

Patient clinical details

Description of symptoms, including onset & duration	
Relevant medical history	
Disease management to date	
Current medications	

Visual function[1,2]	BCVA	OD		OS		
	Visual field defect?	OD	☐ Yes ☐ No	OS	☐ Yes	☐ No
Imaging results[1,2]	OCT imaging	OD		OS		
	Fluorescein angiography	OD		OS		
	ICG angiography	OD		OS		

BCVA, best corrected visual acuity; ICG, indocyanide green;
OCT, optical coherence tomography; OD, oculus dexter (right eye); OS, oculus sinister (left eye)

1. Dick AD et al. *Ophthalmology* 2018;125:757–73; 2. Jabs DA et al. *Am J Ophthalmol* 2005;140:509–16;
3. Jabs DA et al. *Am J Ophthalmol* 2000;130:492–513; 4. Constantin T et al. *Ann Rheum Dis* 2018;77:1107–17.

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Why are you referring the patient?[1,3,4]

- [ ] Chronic or recurrent uveitis
- [ ] Bilateral uveitis
- [ ] Sight-threatening uveitis
- [ ] Uveitis impacting patient's life significantly
- [ ] Poor visual acuity (≤20/100) or vitreous haze ≥2 in at least one eye
- [ ] Retinal, macular, or optic nerve involvement, or choroiditis
- [ ] Active disease despite intra- or periocular corticosteroid injection
- [ ] Active disease despite high-dose (≥20 mg/day) oral corticosteroids
- [ ] Patient has been on high-dose (≥20 mg/day) oral corticosteroids for more than one month
- [ ] Active disease despite being on corticosteroids for >3 months
- [ ] Disease relapses upon steroid tapering below 7–10 mg/day of prednisone
- [ ] Patient intolerant to corticosteroids or corticosteroids contraindicated
- [ ] Patient experiencing corticosteroid-related side effects and in need of corticosteroid-sparing treatment
- [ ] Other (please specify below)

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1. Dick AD et al. *Ophthalmology* 2018;125:757–73; 2. Jabs DA et al. *Am J Ophthalmol* 2005;140:509–16;
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Red flags for initiating non-corticosteroid systemic therapy

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If you are not confident or unable to initiate non-corticosteroid systemic therapy yourself, your patient may need to be referred for additional assessment.

Disease severity indicators

1	Is your patient's non-anterior uveitis chronic or recurrent?	☐ Yes	◯ No
2	Is your patient's disease bilateral?	☐ Yes	◯ No
3	Would you consider your patient's non-anterior uveitis sight-threatening?	☐ Yes	◯ No
4	Does your patient's non-anterior uveitis considerably affect their daily life?	☐ Yes	◯ No
5	Is your patient's visual acuity worse than 20/100 in at least one eye?	☐ Yes	◯ No
6	Has your patient's vitreous haze increased beyond grade 2 since diagnosis?	☐ Yes	◯ No
7	Does your patient's non-infectious uveitis show retinal, macular, or optic nerve involvement (e.g. retinitis, retinal detachment, retinal vasculitis, macular edema, papillitis), or choroiditis?	☐ Yes	◯ No

Treatment-related indicators

A decrease in visual acuity, or an increase in anterior chamber cell count or vitreous haze are among the parameters that can influence the decision to adjust therapy.

1	Is your patient's disease active despite intra- or periocular corticosteroid injection?	☐ Yes	◯ No
2	Is your patient's disease active despite taking daily oral corticosteroid doses of ≥20 mg or 0.5 mg/kg for 2–4 weeks?	☐ Yes	◯ No
3	Has your patient been on ≥20 mg or 0.5 mg/kg of oral corticosteroids a day for more than one month?	☐ Yes	◯ No
4	Has your patient's uveitis been active despite being on corticosteroids for more than three months (any dose and mode of administration)?	☐ Yes	◯ No
5	Does your patient's uveitis reactivate when reducing the dose of oral corticosteroids below 7–10 mg/day?	☐ Yes	◯ No
6	Is your patient intolerant to corticosteroids or are corticosteroids contraindicated?	☐ Yes	◯ No
7	Has your patient experienced any significant corticosteroid-related side effects, such as weight gain, mood changes, lack of sleep, cataracts, and changes in blood glucose levels or bone mineral density?	☐ Yes	◯ No

1. Dick AD et al. *Ophthalmology* 2018;125:757–73; 2. Jabs DA et al. *Am J Ophthalmol* 2000;130:492–513;
3. Constantin T et al. *Ann Rheum Dis* 2018;77:1107–17.
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Co-management form

To enable a two-way dialog between general ophthalmologist and uveitis specialist

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To be completed by uveitis specialist

Patient name

Management since referral

Additional tests performed

Additional tests outcomes

Alternative diagnosis?

Other management, incl. medication prescribed

Additional comments

Ongoing management

Regular appointments required?

Yes ☐ No ☐

Purpose of regular appointments[1,2]

Assess treatment response ☐ Monitor recurrence of inflammation ☐

Monitor visual function ☐ Monitor side effects ☐

Other

Frequency of appointments
Can be based on disease severity

Consider change in management or refer back to specialist if:[1-3]

Patient does not respond to, or deteriorates on, treatment ☐
Can be measured by anterior chamber flare, vitreous haze, and retinal, macular, or optical nerve involvement

Visual acuity worsens ☐

Symptoms recur after period of quiescence ☐

Treatment leads to significant side effects ☐

Other

Additional comments

1. Dick AD et al. *Ophthalmology* 2018;125:757–73; 2. Constantin T et al. *Ann Rheum Dis* 2018;77:1107–17;
3. Jabs DA et al. *Am J Ophthalmol* 2000;130:492–513.

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Non-infectious uveitis specialist center checklist

A specialist center for non-infectious uveitis should generally…

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Have access to trained staff

- [ ] Ocular immunologist/uveitis specialist

  OR

- [ ] Retina specialist with experience of treating ocular inflammation in conjunction with a physician trained in immunomodulatory therapy

- [ ] Supportive ophthalmic specialists (glaucoma, vitreoretinal specialists)

- [ ] Non-ophthalmic specialists to support patients whose NIU is associated with systemic disease (rheumatologist, gastroenterologist, neurologist, nephrologist, pulmonologist, etc.)

- [ ] Desirable: specialist nurses in uveitis (for counselling, training patients, monitoring immunosuppression), optometrist

Have access to diagnostic technologies

- [ ] Fluorescein angiography, ICG, OCT, electrophysiology

Provide comprehensive patient care

- [ ] Focus on holistic, medical management of patients

- [ ] Prescription of systemic treatment
  - Non-biologic systemic treatments (azathioprine, methotrexate, cyclosporine A, mycophenolate mofetil, tacrolimus)
  - Biologic systemic treatments (adalimumab, infliximab, interferon α2)

- [ ] Monitoring of treatment response and side effects (if a shared management approach with a general ophthalmologist, primary care physician or other physician is not possible)

- [ ] Management of adult and pediatric patients

ICG, indocyanide green; NIU, non-infectious uveitis; OCT, optical coherence tomography.

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