Triage for
The Optometric Assistant

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The Basic Rules of History Taking

Phone triage has a few common traits with any phone call. Ultimately, you want to get as much pertinent information as possible in order to help you, or the medical staff that you work with, to make accurate decisions on the proper care of the patient. First, we will review what hopefully seems to be common knowledge--phone etiquette.

Phone Etiquette

In any phone call you want to be polite and courteous and at the same time concise and professional. Like any phone call there are a few important facts that you should obtain from EVERY caller, regardless if it regards to phone triage or taking a message for a member of the staff or physician. Those basic facts are listed below:

- **Who called?**
- **Who do they want to talk to?**
- **When did they call?**
- **What is their phone number? (In case we need to call them back)**
- **Do they want us to call them back or will they call?**

Quantitative/Qualitative Information

As we said earlier, the mission of any one responsible for phone triage is to obtain as much pertinent information as possible in a relatively short period of time. In the rest of this page we will talk about a method that will be helpful not only for phone triage but also for medical history taking when the patient is in the office. When ever triaging a patient over the phone have a pen and paper or access to a computer to document the discussion. It is very difficult to remember all of the facts of a phone conversation. By writing it all down it will aid in recall when you discuss the case with the doctor or provide a good template for you to review your decision tree (We will talk more about this later). We will discuss one of the more common formats in the following sections. Please be sure to follow this format on every patient so you can gain as much information as possible in a standardized way.

- Chief Complaint
  Basically put-why are they calling or what is the principle reason they are calling. This is known as the patient's chief complaint. It may be as simple as their eye is red or they have blurred vision.
- FODLAR
  FODLAR relates to a format of obtaining quantifiable information in a standardized format. This is also known as the history of present illness (HPI). By obtaining the answer to these 6 questions you will gain the information needed to help make most decisions on the next step for the patient you are dealing with. These are necessary elements for any office examination. FODLAR is an acronym that can help you to remember the following list of questions:
  - **F= Frequency--How often are the symptoms occurring?**
  - **O= Onset---When did the symptoms begin?**
  - **D= Duration--How long have the symptoms lasted?**
  - **L= Location--Where do you notice the problem?**
  - **A= Association--Is there anything else related to the symptoms or problem?**

- R= Relief from Symptoms--Does anything help relive or diminish the symptoms or problems?
- Decision-Making

Once you have obtained a chief complaint and FODLAR you are ready to make an informed decision or give the appropriate information to someone else who is more qualified to make those decisions. Throughout this course we will divide decision making into three categories depending on their importance or timing in which they need to be seen. These categories are listed below:

1. Emergency Appointment
2. Same Day Appointment
3. Non-Emergent Appointment

At the end of this course we will have a "decision-tree" which you may find helpful and even decide to print out for use in your office.

Documentation

On any patient you should document all of the components of good phone etiquette that we discussed in addition to the chief complaint and the result of your HPI or FODLAR. This documentation will help assist those who are making a clinical health decision as well as serve as a template for the patient visit. You may suggest to your office manager or supervisor that a protocol be set for your office so everyone is documenting phone calls in a uniform fashion.

SAMPLE QUESTION

1. Which of the following items should NOT be included in a comprehensive medical history?

A. Religious Affiliation
B. Past Ocular History
C. Current Medications
D. Drug Allergies

See Answer at end of last page

Vision Changes

In this section of the course we will talk about one of the more common patient complaints. Changes in vision are one of the more diverse and challenging complaints that you may receive over the phone. Vision changes can take many forms and be caused by a multitude of things. Let's take a look at some of them.

1. *Loss of Vision*

   Any time a patient reports that they are experiencing a loss of vision you need to quickly determine a few basic facts. We have listed the questions in the table below. Once again, you are using the basic concepts that we discussed on the first page of this course to find out when it started, the duration of the loss, the location and associated symptoms. There are a variety of potential causes of vision loss as illustrated in the differential diagnosis box in the right margin. Some of these disorders are not only visually threatening but also life threatening so all cases of vision loss are considered an ocular emergency and should be seen immediately (within 24 hours) for an extended exam.

Possible Causes of Vision Loss
Unilateral without Pain • Ischemic Optic Neuropathy • Retinal Detachment • Central Retinal Artery Occlusion • Central Retinal Vein Occlusion • Amaurosis Fugax • Vitreous Hemorrhage
Unilateral with Pain • Acute Angle Closure Glaucoma
Bilateral • Malignant Hypertension • Migraine • Stroke • Cerebral Hemorrhage • Increased Intracranial pressure • Aneurysm • Trauma

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2. *Double Vision*

Patients who report double vision also must be handled very carefully because of the range of possible causes. Once again, while performing telephone triage you can NOT make a diagnosis. Your principle role is to obtain as much pertinent information as possible for the doctor to make an informed decision about the urgency of seeing the patient. We have again listed the questions you need to ask anyone who reports double vision. As a standard rule if the double vision is of acute onset (the last 48 hours) then this is considered a high priority emergency and the patient should be seen immediately or at least the same day. If the double vision has been present for more than one week then the patient should be seen within the same week. If you are unsure about when to have the patient seen be sure to ask the doctor that you are working with.

Questions to Ask

1. **Is it in one or both eyes?**
2. **When did you first notice the double vision?**
3. **Does it come and go or is it there all the time?**
4. **How long has it been double?**
5. **Is the eye painful?**
6. **Have you had surgery or trauma to the eye recently?**

Possible Causes of Double Vision

Unilateral
- **Displaced IOL**
- **Retinal Detachment**
- **Orbital/Ocular Tumor**

Bilateral
- **Blow out Fracture**
- **Pupil Involved 3rd Nerve Palsy**
- **3rd Nerve without pupil**
- **4th Nerve Palsy/Disorder**
- **6th Nerve Palsy/Disorder**

3. *Blurred or Distorted Vision*

Patients who report that their vision is blurred or distorted comprise the greatest amount of phone calls that you will receive. While the majority of these patients are in need of an eye exam because they have had a change in their prescription, there are a few key questions you need to ask to rule out some other possible problems. In most cases vision distortion is not an emergent situation and can be scheduled for an appointment within the next 2-3 days. In situations where the eye is painful they will likely need to be seen sooner. We will be discussing painful eyes more in the following pages. We wanted to show you some of the more common ocular motility (eye muscle) problems that may cause double vision or distorted vision.

Questions to Ask

1. **Is the vision change in one or both eyes?**
2. **When did you first notice your vision getting blurry?**
3. **Is the vision affected all day long or does it come and go?**
4. **Do you ever lose your vision completely?**
5. **Is the eye painful?**
6. **Have you had surgery or trauma to the eye**

Possible Causes of Blurred or Distorted Vision

Unilateral
- **Painful**
  - **Angle Closure Glaucoma**
  - **Endophthalmitis**
  - **Iritis, Scleritis**
  - **Corneal Ulcer/RCE**
  - **Ocular Surface Disease**
  - **Corneal Edema**
- **Non-Painful**
  - **Rx Change**
  - **Macular Degeneration**
  - **Diabetic Retinopathy**
  - **Displaced IOL**
  - **Retinal Detachment**
  - **Orbital/Ocular Tumor**

Bilateral
- **RX Change**
- **Motility Disorder**

SAMPLE QUESTION

2. It is important to ask which eye is being affected in which of the following conditions:

A. Double Vision
B. Acute Vision Loss
C. Distorted Vision
D. All of the Above

See Answer at end of last page

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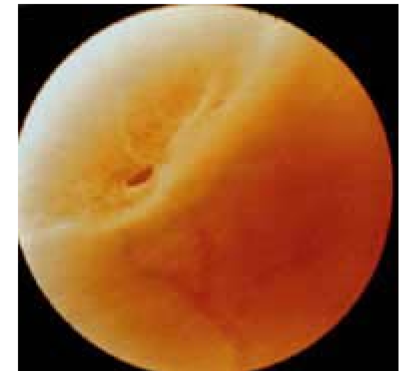
Flashes, Floaters & Veils

If there is one set of symptoms that will immediately catch the attention of an experienced clinical technician it is this next one. Symptoms of flashes, floaters or a curtain (or veil) over someone's vision could signify many potential ocular or systemic disorders. We have listed some of the more common questions that will help differentiate the various causes in the graph to the left. We have also listed the possible causes of these symptoms in the table in the right margin. As you will notice the determination of which eye (or both) is affected plays a key role in determining the cause of these symptoms. We have included a picture of a tractional retinal detachment below. This is the most visually threatening of the potential causes of monocular flashes and floaters. Since it is impossible to differentiate a retinal detachment from a vitreal detachment without a thorough dilated exam all cases of unilateral flashes, floaters or veils must be seen the same day, regardless of the time they call in. Granted, these are usually the 5:00 Friday afternoon calls but because of the seriousness of the condition they need to be seen immediately. A little note on what is actually happening to give these symptoms: Our retinal cells are not able to differentiate between light hitting them and something tugging on them. Either way they fire a stimulus off that is "sensed" as a flash of light. When the vitreous pulls away from the retina it usually does so in a linear fashion so the patients sees a linear flash of light. From this point one of three things happen:

Questions to Ask

1. When did you start to notice the flashes or floaters?
2. Are they in one or both eyes?
3. Is the vision blurry or is all or part of it missing?
4. Do you notice a curtain or dark area progressing

Possible Causes of Flashes & Floaters
Unilateral • Retinal Detachment • Posterior Vitreal Detachment • Amaurosis Fugax • Central Retinal Artery Occlusion
Bilateral • Pre-Migraine Aura • Transient Ischemic Attacks • Choroiditis



1. It is a nice clean separation and the patient may or may not notice the quick flash of light and the vitreous detaches cleanly from the retina.
2. As the vitreous detaches it pulls the retina off with it leading to a curtain-like effect of darkness as the retina pulls away from its blood supply and everything goes dark.
3. The vitreous pulls away and little chunks of the outer retina or chunks of the jelly-like vitreous are left floating in the back part of the eye. These "floaters" then cause a grey shadow on the retina when bright lights hit the edges. (This is why people usually notice floaters in bright light situations.) In some instance a small piece of the retina can be pulled off leaving a small hole. Fluid from the eye then leaks into the hole pulling the retina off and the symptoms of #2 arise. You can see an example of this in the picture to the left.

Patients with bilateral symptoms pose a larger threat to the overall health of the patient. In situations of transient ischemic attacks (TIA's) there is a potential for stroke and even death

SAMPLE QUESTION

3. "Floaters" affecting both eyes are often caused by which of the following:

A. Central Retinal Artery Occlusion
B. Transient Ischemic Attack
C. Posterior Vitreal Detachment
D. Retinal Detachment

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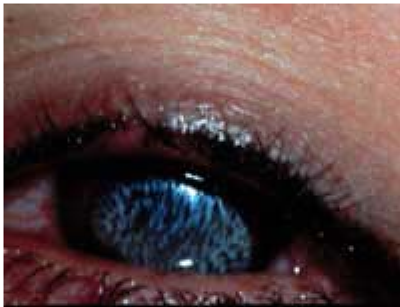
Burns

Though ocular surface burns are not quite as common as some of the other conditions that we have discussed so far it is one of the more emergent situations that a phone triage person may need to deal with. Once again, we have listed some of the more common questions that need to be asked. It is critical that you obtain the timing of the injury and the exact name and concentration of the chemical that is now in the patient's eye. The greater the concentration and the greater the contact time with the ocular surface the greater the potential damage that can occur. This is one of the only ocular emergencies where you will NOT bring the patient in to be seen first. In chemical burn situations, the most important thing is to dilute the chemical as much as possible. The standard rule is to instruct the patient to immediately flush their affected eye with tap water for approximately 30 minutes. It is essential that the patient does not try to play amateur chemist and try to dilute the alkali that they got in their eye with some acid of the shelf. Tap water or distilled water will work nicely. Once they have flushed their eyes for 30 minutes then they can come in where they will most likely be flushed again for another 30 minutes before the damage is assessed. One of the more common appearances of a chemical burn is shown in the picture above.

Questions to Ask
1. What did you get splashed in your eye with?
2. When did this happen?
3. Did both eyes or only one get chemical in it?
4. Is the vision blurry?
5. Is (Are) the eye(s) red?
6. Have you already tried

Chemical Burn



Thermal Burns also can do significant short term damage. The picture to the left is a cornea that got a little too friendly with a curling iron. Ouch!!!!
In situations of a thermal burn the patient should still rinse their eye to ensure there will be no prolonged chemical exposure, as well as to "cool" the eye and slow down the inflammation. They will be treated a little differently than a chemical burn when they are seen by the doctor but in the short-term they are treated very much the same as a chemical burn.

SAMPLE QUESTION
4. When a patient calls stating that they spilled some chemical in their eye you should ask which of the following questions:
A. What did you get splashed with?
B. Which eye is affected?
C. Did you already flush the eye with water?
D. All of the above are correct

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Foreign Body or Ocular Trauma

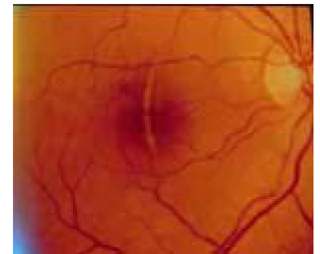
In situations where there is a known trauma or the presence of a foreign body in or around the eye there are a few basics questions that you need to ascertain before the patient gets off the phone. Most of these questions are listed in the graph to the left. Trauma incorporates a wide variety of possible ocular disorders. It can include chemical or thermal burns in or around the eye as we discussed on the last page. Trauma can also include what is known as blunt trauma. This type of trauma occurs when there is no penetration of the ocular surface and eyeball but the initial force to the eye is great enough to cause other forms of damage. An instance of this damage as seen in the picture to the right. A list of those possible findings is presented in the table to the right as well. As you can see, the list is pretty long and the process of eliminating each one of them is even longer. Patients suffering from any of these disorders may also present with other symptoms discussed elsewhere in this course. Any time you have a patient calling in with reports of any of the conditions we discuss in this course you should inquire about a recent history of trauma to the eye. We especially want to give a little extra attention foreign bodies. Foreign bodies can be metallic, organic or inert. Since the eye ball is pretty tough it can withstand most types of trauma without rupturing. We have shown a few different examples of foreign bodies at the bottom of the page. However, sharp or hot object that travel at high speeds can either get stuck in the ocular surface or actually penetrate the eye. Since you are unable to tell where the foreign body is, all patients who report a recent history of ocular trauma should be seen on an immediate basis.

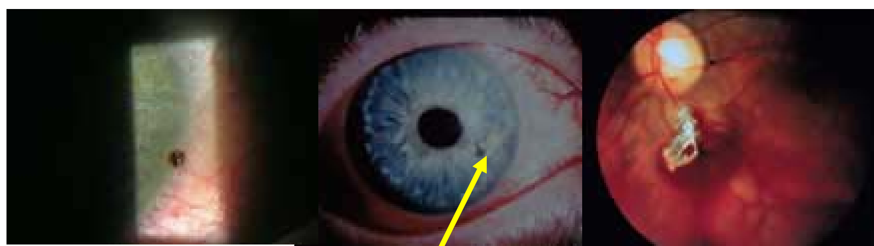
Questions to Ask

1. Which pupil is larger?
2. Have the eyes always been a different size?
3. When did you first notice that they were different?
4. Is there any recent trauma to the eye or head?
5. Have you used any types of new drugs or skin patches lately?
6. Are you having any

Possible Disorders Associated with Trauma

1. Lid contusion/swelling
2. Lid laceration
3. Corneal abrasion
4. Corneal laceration
5. Post-traumatic Iridocyclitis
6. Hyphema
7. Iridodialysis
8. Pupillary Miosis/Mydriasis
9. Lens Subluxation
10. Cataract
11. Vitreal Detachment
12. Retinal Detachment
13. Retinal Edema/Hemorrhage
14. Traumatic Choroiditis
15. Chroidal Effusions
16. Intraocular foreign body





Metallic Corneal Foreign Body

Intraocular Foreign Body

SAMPLE QUESTION

5. A patient reports that they think they were hit with a piece of rust while they were working on their car but can not find anything in their eye. What to you do?

A. Set an appointment for next week

B. Tell them not to worry that they will be fine in a few days

C. Set them up for an appointment today

D. Tell them to go to the ER for an MRI immediately

See Answer at end of last page

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Pupil Changes

Any time a patients calls in reporting that they have had a change in the size or shape of one or both of their pupils little bells should go off in your head. Pupil changes can be due to a variety of things as illustrated in the table in the right margin. Some of these potential causes are fairly benign and insignificant while others are not only visually threatening but also life threatening. For example, a dilated pupil in one eye only could be as simple as getting a drop of some chemical that acts to dilate the eye OR it could be an aneurysm in the brain.

Possible Causes of Pupil Changes

Acute Onset
1. **Contact with dilating agent**
2. **Trauma**
3. **Iritis**
4. **3rd nerve palsy**
5. **Aneurysm**

> 48 hours
1. **Iritis**
2. **Diabetic Third Nerve**
3. **Adie's Pupil**
4. **Horner's Pupil**
5. **Other neurological cause**

Questions to Ask
1. **Which pupil is larger?**
2. **Have the eyes always been a different size?**
3. **When did you first notice that they were different?**
4. **Is there any recent trauma to the eye or head?**
5. **Have you used any types of new drugs or skin patches lately?**
6. **Are you having any**

It is very important for any one that performs phone triage to ask the questions listed in the table to the left. The answers to the questions on this list will be very beneficial when the doctor has to make a differential diagnosis. In general, if the symptoms start within the last 48 hours this is a cause for concern and the patient should be seen immediately. If the symptoms are more than 48 hours old then the appointment should be as soon as possible and definitely within the next two days.

In some situations one pupil may be larger than the other. This may due to a dilating agent that the larger eye has been exposed to. This includes motion sickness patches and certain kinds of insecticides and plant by-products. Trauma can also cause temporary or permanent changes in pupil size (See the picture to the right). In some circumstances the cause may be much more serious and further testing will be necessary. In the case of the picture below you will notice that this boy's right pupil is significantly larger than his left. This could mean a variety of conditions depending on which pupil is the normal size, the right or the left. In his case he has a condition called Horner's syndrome and the larger pupil is the problematic eye. . Patients who also suffer from double vision may likely have associated ocular motility problems that are causing the double vision. Be sure to take our "Pupils" course at some point in the future to learn more about the action and function of the pupil.

SAMPLE QUESTION

6. Pupil changes can be caused by any of the following EXCEPT

A. Small Refractive Error
B. Trauma
C. Third Nerve Palsy
D. Pharmaceuticals

See Answer at end of last page

Painful Eye

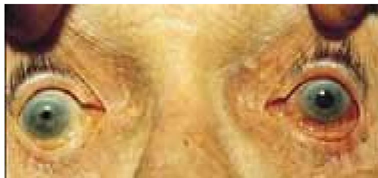
Many patients will call in reporting that their eye is painful. True ocular pain is very different from ocular discomfort so as the recipient of the phone call you must carefully assess what types of problems the patient is having. In addition to the problems listed in the table to the right you should also carefully asses if there are any other associated symptoms or events surrounding the painful eye. Some of these conditions we discussed in other sections of this course so be sure to review these. Truly painful eyes may pose serious threats to the patient's vision and should always be seen on an emergent basis. Other cases of ocular discomfort will be discussed in the following pages so you can gain an understanding of the differences between the two symptoms. We have demonstrated some of the more common causes of ocular pain in the blue box to the right.

Possible Causes of A Painful Eye
1. Ileitis/Iritis
2. Severe Allergic Reaction
3. Corneal Edema
4. Corneal Abrasion
5. Corneal Ulcer
6. Scleritis
7. Recurrent Corneal Erosion
8. Acute Angle Closure
9. Severe Dry Eye

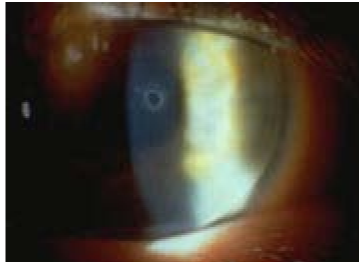
Questions to Ask

1. **When did the pain start?**
2. **Does it affect one or both eyes?**
3. **Is it all the time or intermittent and when?**
4. **Have you had a similar incidence of this before?**
5. **Does anything make the pain better?**
6. **Is there any recent trauma to the eye or head?**
7. **Do you wear contacts?**

Corneal Thermal Burn



Acute Angle Closure Glaucoma



Recurrent Corneal Erosion

SAMPLE QUESTION

7. Which of the following items can lead to a painful eye?

A. Retinal Detachment
B. Infectious Corneal Ulcer
C. Glasses Rx Change
D. All of the above are correct

See Answer at end of last page

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Red Eye, Tearing or Discharge

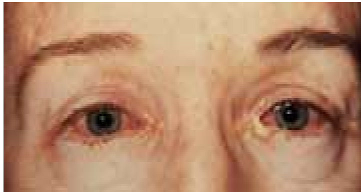
Now that we have discussed patients who report suffering from pain in or around the eye we need to look at an often associated complaint of a red eye or one that has tearing or discharge. The etiology or cause of any of these symptoms can be variable.

Questions to Ask

1. **Is the vision totally red or is the eye red?**
2. **When did you first notice the eye being red?**
3. **Are they red all day long or only certain times of the day?**
4. **Which eye or both eyes are red?**
5. **Do you wear contacts?**
6. **Have you had eye surgery recently?**
7. **Do you have any associated pain?**
8. **Were you hit in the Eye?**

We have listed some of the more common causes of red eyes and eyes that have discharge in the blue table in the right margin. Review these tables carefully and then read the "*Questions You Should Ask*" section to see if you can identify what the answers will be for each condition. In general red eyes or eyes with minimal to moderate discharge are not considered an ocular emergency and should be seen within the next few days. There are a few exceptions to those rules however. Contact lens wearers have a significantly higher risk of corneal infection that could potentially cause permanent vision loss. All contact lens patients who complain of a red eye should be seen immediately. Patients who have recently had ocular surgery should also be seen on an emergent basis to rule out infection or severe inflammation within the eye that has happened as a complication of the original surgery. A few comments on the question you should ask. The first question is to determine if the vision is red signifying that they have a hemorrhage inside the eye. If the eye is red there may be a problem on the external part of the eye. If both eyes are red it is more likely that the problem is either environmental, like allergic conjunctivitis, or infectious like bacterial conjunctivitis (shown above). In contrast when the problem is only in one eye it may be any of the causes already discussed, in addition to many others on the differential diagnosis list.

Possible Causes of Red Eye with Tearing and/or Discharge
Painful 1. Acute Angle Closure 2. Corneal Ulcer 3. RCE 4. Corneal Abrasions 5. Corneal Foreign Bodies **Non-Painful** 1. Infectious Conjunctivitis 2. Allergic Conjunctivitis 3. Subconjunctival Hemorrhage 4. Keratitis 5. Episcleritis



SAMPLE QUESTION

8. Which of the following may be the cause of bilateral red eyes?

A. Recent Cataract Surgery, right eye
B. Recurrent Corneal Foreign Body, left eye
C. Infectious Corneal Ulcer
D. Allergic Conjunctivitis

See Answer at end of last page

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Swollen Eyelids

The last subject that we need to cover because it is a fairly common complaint is swollen eyelids. As with each section we have listed the common questions that you should ask any patient who reports that they have swollen eyelids.
We also have listed some of the more common or at least potential causes of swollen eyelids. In most situations these patients should be seen the same day they call or the very next day. Once again, use common sense and if you are not sure what to do always ask the doctor or a more experienced technician. We have demonstrated a few of the more common types of swollen eyelids in the section below.

Questions to Ask

1. **When did you first notice the eyelids being swollen?**
2. **Which Eyelid is swollen? (One/Both, Upper/Lower)**
3. **Have there been any changes to your vision?**
4. **Is it Painful?**
5. **Which eyelid is affected?**
6. **Have you had eye surgery recently?**
7. **Were you hit in the Eye?**

Possible Causes of Swollen Eyelids
Hordeolum Chalazion Allergic Reaction Contact Dermatitis Impetigo Orbital Diseases Orbital cellulitis Acute Viral Inflammations Cavernous Sinus Thrombus Tumors

Chalazion

Pre-septal Cellulits

SAMPLE QUESTION
9. Swollen eyelids are never the sign of a serious problem
A. True
B. False

See Answer at end of last page

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Summary

In this course we have learned about many different types of ocular diseases and the ways that they commonly present when patients call in with problems. This course is meant to give you a general overview of some of the more common symptoms or chief complaints that you may hear over the phone. It is not an all inclusive list and there are many things we did not cover in this course. As a quick review, remember that you want to get as much pertinent information as possible in order to help you or the medical staff that you work with make accurate decisions on the proper care of the patient. Phone etiquette is equally important to remember because not only are you trying to help them medically but you are also the representative of the practice and you must meet your patient's needs.

Remember to use an acronym (like FODLAR) to help remember what questions you need to ask any patient who calls in with symptoms that we have discussed. Now remember that the symptoms that we discussed in this course are just some of the more common complaints that you may get. As we said on this page, this list is not inclusive and you may come up against many other different symptoms. They key is to use common sense and ask good questions. If you are unsure on what to do talk to your doctor and ask them what they would like your next step to be, whether it is making an appointment, trying to obtain more information or even making a referral. NEVER GUESS!!! Always document your phone call in the patient's chart (if they are an established patient) or have a phone triage sheet that you can write the answers on (for all new patients). Always ascertain their chief complaint and as much information as you can. If you do not remember any of the acronyms we discussed earlier you may want to visit page 1 again before taking the test.

Sample Test Answers
1. A 2. D 3. B 4. D 5. C 6. A 7. B 8. D 9. B 10. C

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