
Appendix 1. Preventative eye care clinical indicators

History Taking

- 1 Patients presenting for initial comprehensive eye exam should have the following documented:
 - name, AND
 - age, AND
 - ethnicity, AND
 - gender, AND
 - driving status, AND
 - chief complaint, AND
 - current medication and allergies, AND
 - ocular history, AND
 - medical history, AND
 - Presence of diabetes mellitus, AND
 - ocular family history, AND
 - medical family history.

Clinical Assessment

- 2 Patients presenting for comprehensive eye exam should have the following assessments performed and documented:
 - habitual visual acuity (VA) at distance, AND
 - habitual VA at near, AND
 - best corrected monocular VA with refraction at distance, AND
 - best corrected binocular VA with refraction at distance, AND
 - best corrected binocular VA with refraction at near, AND
 - anterior eye examination, AND
 - intraocular pressure (IOP) taken more than once, AND
 - IOP instrument recorded, AND
 - IOP time recorded, AND
 - optic nerve head examination, AND
 - fovea examination.

Recall Period

- 3 Patients aged ≥ 19 and ≤ 39 with no identified risk are advised to undertake comprehensive eye examination checks at least every 5 years.
 - 4 Patients aged ≥ 40 and ≤ 64 are advised to undertake comprehensive eye examination at least every 2 years.
 - 5 Patients aged ≥ 65 are advised to undertake comprehensive eye examination at least 1 year.
 - 6 Patients with diabetes should be advised to undertake comprehensive eye examination at least every 2 years.
 - 7 Caucasians, aged >50 are advised to undertake regular comprehensive eye examination.
 - 8 Africans, aged >40 are advised to undertake regular comprehensive eye examination.
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Appendix 2. Glaucoma clinical indicators

History Taking

- 1 Patients assessed for OR with glaucoma should have the following documented during the initial visit:
 - age, AND
 - ethnicity, AND
 - personal ocular history, AND
 - general health history, AND
 - history of migraine, AND
 - smoking status, AND
 - current ocular medication, AND
 - current systemic medication, AND
 - current and past steroid use, AND
 - family ocular history, AND
 - diabetic status, AND
 - high blood pressure, AND
 - low blood pressure, AND
 - Raynaud's syndrome.
- 2 Patients assessed for OR with glaucoma should have the following documented during the glaucoma follow-up examination:
 - interval ocular history, AND
 - interval systemic medical history, AND
 - side effects of ocular medications, AND
 - frequency and dosage of medication use, AND
 - time of last IOP-lowering medications, AND
 - review of use of medications.

Clinical Assessment

- 3 Patients assessed for glaucoma OR with ocular hypertension (OHT) OR newly diagnosed glaucoma should have a glaucoma examination performed and documented or referral for the following procedures is organised:
 - habitual VA, at both distance, AND
 - pupil reaction, AND
 - intraocular pressure (IOP), AND
 - the time of IOP measurement, AND
 - type of IOP measurement (applanation/Goldmann/non-contact tonometer), AND
 - central corneal thickness at regular intervals, AND
 - anterior ocular health by slit lamp, AND
 - peripheral anterior chamber configuration by gonioscopy OR van Herick's peripheral anterior chamber depth assessment, AND
 - size of optic disc, AND
 - cup/disc ratio, AND
 - pattern of the neuroretinal rim, AND
 - presence of disc rim haemorrhage, AND
 - presence of thinning of the nerve fibre layer, AND
 - imaging of optic disc AND/OR optic nerve fibre AND/OR fundus photography, AND
 - visual field examination.

Management

- 4 Patients with glaucoma AND asthma should NOT be treated with non-selective beta-blockers

(Timolol OR Tenopt OR Timoptol OR Ganfort OR Combigan OR Azarga OR Cosopt OR Xalacom OR Latanocom OR Duotrav).

- 5 Patients with newly diagnosed glaucoma should be treated with topical prostaglandin analogue (Bimatoprost/Latanoprost/Tafluprost/Travoprost), unless contraindicated, OR selective laser trabeculoplasty

Recall Period

- 6 Patients with suspected glaucoma should be advised to have a glaucoma follow-up examination within 6 to 18 months.
- 7 Patients with suspected glaucoma (low risk) should be advised to have a glaucoma follow-up examination within 6-24 months.
- 8 Patients with suspected glaucoma (high risk) AND are treated AND archiving target should be advised to have a glaucoma follow-up examination within 3-6 months.
- 9 Patients with suspected glaucoma (high risk) AND are treated AND without archiving target IOP should be advised to have a glaucoma follow-up examination within 4 months.
- 10 Patients with early glaucoma should be advised to have a glaucoma follow-up examination within 12 months.
- 11 Patients with moderate glaucoma should be advised to have a glaucoma follow-up examination within 6 months.
- 12 Patients with advanced glaucoma should be advised to have a glaucoma follow-up examination within 4 months.

Referral

- 13 Patients (assessed for glaucoma OR with OHT) AND are treated AND NOT achieving target IOP should be referred to ophthalmologist.
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Appendix 3. Diabetic eye care clinical indicators

History Taking

- 1** Patients with diabetes should have the following documented:
duration of diabetes, AND
most recent HbA1c result OR self-reported level of blood glucose control, AND
presence of history of high blood pressure (hypertension), AND
presence of history of dyslipidaemia (high cholesterol).

Clinical Assessment

- 2** Patients with diabetes should have the following assessments performed and documented:
visual Acuity, AND
examination of iris, AND
a dilated fundus exam OR retinal photography with grading.

Referral

- 3** Patients with diabetes with a suspicion of macular ischemia AND clinically significant macular oedema (CSME) should have or be referred for fluorescein angiography.
- 4** Patients with diabetes presenting with any reduction in best corrected visual acuity that is suspected to be due to diabetic retinopathy (DR) should be referred to an ophthalmologist within 4 weeks.
- 5** Patients with diabetes presenting with suspected diabetic macular oedema (possible/suspected thickening, hard exudate, oedema) should be referred to an ophthalmologist within 4 weeks.
- 6** Patients with diabetes presenting with proliferative diabetic retinopathy (PDR) should be referred to an ophthalmologist within 4 weeks.
- 7** Patients with type 1 diabetes presenting with persistent vitreous haemorrhage should be referred to an ophthalmologist.

Management

- 8** Patients with diabetes AND cataract presenting with diabetic macular oedema should have macular laser before cataract surgery if possible OR intravitreal anti-vascular endothelial growth factor (anti-VEGF) therapy before or at the time of cataract surgery.
- 9** Patients with diabetes presenting with severe NPDR should have laser photocoagulation or receive close follow-up (every 4 months or more frequently).
- 10** Patients with diabetes presenting with PDR, AND NO maculopathy should have panretinal photocoagulation (PRP) scheduled.
- 11** Patients with diabetes presenting with PDR (excluding high risk PDR and advanced PDR), AND CSME should have macular laser treatment OR anti-VEGF treatment BEFORE PRP.
- 12** Patients with type 1 diabetes AND PDR should have PRP.
- 13** Patients with NV at iris (rubeosis) should have PRP.

Recall Period

- 14** Patients with diabetes AND NO DR should have been advised to have their eyes examined at least every 2 years.
 - 15** Patients with diabetes AND mild non-proliferative diabetic retinopathy (NPDR) should have been advised to have their eyes examined at least every 1 year.
 - 16** Patients with diabetes AND moderate NPDR should have been advised to have their eyes examined at least every 6 months.
 - 17** Patients with diabetes AND severe NPDR should have been advised to have their eyes examined at least every 3 months.
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