

Patient Triage Form

Patient name: _____ Date: _____ Time: _____

Age: _____ New patient Previous patient Phone number (for the next 30 minutes): _____

Staff name: _____ OD: _____ Last full exam: _____

Which eye is affected? OD OS OU

When did the problem begin? _____ Have you had this happen before? Yes No When? _____

How often does it occur? _____ How long does it last? _____

Is it: Stable Getting worse Improving

Where on your eye is the issue occurring? _____

Is there anything that makes it feel better? _____

Is there anything that makes it feel worse? _____

Do you wear contacts: Yes No Have you removed them: Yes No

Symptom	Sudden/Gradual	Location
Flashing lights		
Curtain or veil		
Floating spots		
Rate Pain*		
Loss of vision		
Foreign body sensation		

Symptom	Sudden/Gradual	Location
Double vision		
Burning		
Itching		
Red		
Discharge (colour)		
Dry		

*Use a scale from 1 – 5 with 1 being mild and 5 severe.

Are you experiencing any other symptoms?

Are you taking any medications?

Comments:

Appt: _____ OD: _____ Follow up: _____

Triage Guide

Symptom	Key Words	EMERGENCY Immediate Attention	URGENT Within 24 Hours (Before 4PM)	PRIORITY Next Available Appointment
Visual Disturbances	<ul style="list-style-type: none"> ▶ Flashing lights ▶ Veil or curtain ▶ Vision loss ▶ Decreased vision ▶ Floaters ▶ Double vision ▶ Halos 	<ul style="list-style-type: none"> ▶ Sudden onset of any of the symptoms ▶ Symptoms occur with or without pain ▶ Increased floaters ▶ Flashing lights 	<ul style="list-style-type: none"> ▶ Noticed symptoms recently ▶ Double or distorted vision with increase in floaters ▶ With or without flashing lights 	<ul style="list-style-type: none"> ▶ Gradual or steady decrease in vision at any distance
Red Eye	<ul style="list-style-type: none"> ▶ Contact lens wearer ▶ Swelling 	<ul style="list-style-type: none"> ▶ Combined with severe pain ▶ Along with an injury 	<ul style="list-style-type: none"> ▶ With moderate or mild pain ▶ Itching and discharge 	<ul style="list-style-type: none"> ▶ Mild and intermittent
Foreign Body	<ul style="list-style-type: none"> ▶ Metal ▶ Got something in eye ▶ Feels like something in eye ▶ Scratched eye 	<ul style="list-style-type: none"> ▶ Metal ▶ Penetrating injury 	<ul style="list-style-type: none"> ▶ Foreign body sensation combined with pain ▶ Scratched eye 	<ul style="list-style-type: none"> ▶ Emergency or Urgent care always required
Pain	<ul style="list-style-type: none"> ▶ Severe (4 – 5)* ▶ Moderate (2 – 3)* ▶ Mild (0 – 1)* ▶ Blow to the eye 	<ul style="list-style-type: none"> ▶ Sudden onset of severe or moderate pain ▶ Especially with vision loss 	<ul style="list-style-type: none"> ▶ Any gradual increase in mild pain 	<ul style="list-style-type: none"> ▶ Mild ache with no other symptoms
Discomfort	<ul style="list-style-type: none"> ▶ Burning sensation ▶ Discharge ▶ Tearing ▶ Itching ▶ Light sensitivity 	<ul style="list-style-type: none"> ▶ Chemical burns ▶ Tearing with severe pain ▶ Foreign body sensation 	<ul style="list-style-type: none"> ▶ Extreme light sensitivity ▶ Constant burning ▶ Any symptoms combined with discharge 	<ul style="list-style-type: none"> ▶ Mild and intermittent itching, burning, or tearing
Eyelid Complaints	<ul style="list-style-type: none"> ▶ Swollen ▶ Drooping ▶ Twitching or fluttering 	<ul style="list-style-type: none"> ▶ Swollen or drooping with trauma or blow ▶ Drooping - sudden onset 	<ul style="list-style-type: none"> ▶ Swollen with mild to moderate irritation ▶ Drooping – gradual onset 	<ul style="list-style-type: none"> ▶ Twitching or fluttering

*Scale from 1 – 5 with 1 being mild and 5 being severe.