Moorfields Eye Hospital NHS Foundation Trust

MOORFIELDS ADULT OCULAR ONCOLOGY REFERRAL FORM

Please e-mail this form to **meh-tr.ocularoncology@nhs.net** with any image(s) of lesion

Referral Date		(Double-click on field to jump to it. Click tab (not return) to save data and move to next field.)

PATIENT DETAILS

Title		First name		Surname	
Gender		DOB		NHS No (if known)	
House & Street					
Town/City			Post code		
Mobile number		Landline		E-mail	

REFERRING OPHTHALMOLOGIST'S DETAILS

General practitioners should refer to optometrists, who should refer (directly) to the patient's local hospital eye service (informing GP).
(Supra-regional ocular oncology centres should receive only tertiary referrals from senior/consultant ophthalmologists.)

Consultant		Person referring		Dept	
Address					
Town/City			Post code		
Phone No			E-mail		

CLINICAL DETAILS

Clinical history									
Tumour location (e.g., iris, conj, etc.)									
Retinal findings	Haemorrhage	☐	Exudates	☐	Detachment	☐			
Images submitted with referral	Fundus photo	☐	Slitlamp photo	☐	FAF	☐	OCT	☐	US	☐

(Please hover over text in MOLES scoresheet below for explanations and suggestions.)

If melanocytic choroidal tumour, please compute MOLES Score to estimate melanoma risk.

Indicator	Finding	Score
Mushroom shape	Absent=0 Early tumour spread through RPE = 1 Present (i.e. definitive mushroom shape with overhang) = 2	
Orange pigment	Absent=0 Trace (i.e., fine hyper-auto-fluorescent specks)=1 Confluent (i.e. easily visible clumps of orange pigment)=2	
Large size	Flat (<1mm thick) and less than 3 disc-diameters (DD) wide=0 Subtle dome shape AND/OR 3-4 DD wide=1 Significant thickening (>2mm) AND/OR more than 4 DD wide=2	
Enlargement*	None (or no baseline photography)=0 Suspected change on comparing photographs=1 Definite growth confirmed by sequential imaging=2	
Subretinal fluid	Absent subretinal fluid on ophthalmoscopy=0 Trace (i.e., confirmed by optical coherence tomography)=1 Definite subretinal fluid visible with ophthalmoscopy=2	
MOLES total score (0=common naevus; 1=low-risk naevus; 2=high-risk naevus; >2=probable melanoma):		
Note:	*Assume growth and score 'Enlargement'>0 if thickness>3 mm or diameter>5 DD.	

SUGGESTED MANAGEMENT OF PATIENTS WITH MORE-COMMON TUMOURS

- **Conjunctival naevus:** Self-monitoring if small and visible in mirror, with photograph. Otherwise, monitoring by ophthalmologistafter 6-12 months. Urgent assessment by ocular oncologist if documented growth or if tumour is non-bulbar.
- **Papilloma:** Treatment by ocular oncologist.
- **Primary acquired melanosis:** Review by ophthalmologist after 6 months then annually. Referral to ocular oncologist if involving most of conjunctiva or if growth is documented photographically.
- **Complexion-associated melanosis:** Reassurance and discharge.
- **Conjunctival squamous/sebaceous intra-epithelial neoplasia:** Urgent referral to ocular oncologist.
- **Nodular conjunctival melanoma / carcinoma:** Urgent referral to ocular oncologist. (Biopsy at local hospital is not advised because of high risk of seeding.)
- **Melanocytic iris tumour:** Monitoring by optometrist if <3 mm wide and flat or by ophthalmologist if 3-5 mm wide and/or elevated. Urgent assessment by ocular oncologist if: (a) tumour involves angle; (b) if diffuse or (c) >5 mm wide.
- **Iridociliary cyst:** Monitoring for glaucoma if known diagnosis. UBM by ocular oncologist if uncertain diagnosis.
- **Congenital ocular melanosis:** Full eye exam with mydriasis (and IOP) by ophthalmologist every 12 months.
- **Disc/iris melanocytoma:** Examination by ophthalmologist after 4-6 months and eventually every 12 months.
- **Congenital hypertrophy of RPE:** Self-care (review by optometrist every 2 years or if seen for other reasons).
- **Common naevus:** Review by optometrist every 2 years or if seen for other reasons.
- **Low-risk naevus:** Non-urgent assessment by ophthalmologist, then long-term surveillance by optometrist at discretion of ophthalmologist.
- **High-risk naevus:** Non-urgent assessment by ophthalmologist, then long-term monitoring, with intensity of surveillance adjusted according to melanoma risk.
- **Melanoma:** Urgent assessment by ophthalmologist with urgent onward referral to ocular oncologist if diagnosis is confirmed.
- **Choroidal haemangioma:** Assessment by ophthalmologist to confirm diagnosis. If subretinal fluid or symptoms, referral to ocular oncologist; otherwise, monitoring by ophthalmologist or optometrist.
- **Suspected vitreoretinal lymphoma:** Urgent multimodal imaging by ophthalmologist with urgent onward referral to ocular oncology centre for vitreous biopsy and multidisciplinary management.
- **Metastasis:** Urgent assessment by ophthalmologist with urgent onward referral to ocular oncologist or, if diagnosis is certain, to local medical oncologist/radiotherapist for treatment.

HOW TO REFER

1. If suspected cancer, refer urgently, following NHS 2-week-wait protocol for suspected cancer (see below).
2. Inform patient of differential diagnosis, need to keep appointment, and what to do if appointment letter is not received by specified date.
3. Optometrists and general pracitioners should refer only to the patient's local hospital eye service (not a supraregional ocular oncology service, which should receive only tertiary referrals from senior ophthalmologists).
4. Refer electronically and securely using NHS e-Referral Service (eRS) or 1st-class post,
5. Include in referral the following:
    a. Patient's name, date of birth, NHS number, address, phone number(s), and e-mail address,
    b. Names, addresses and phone numbers of referrer, general practitioner and optometrist.
    c. Clinical history, ophthalmic findings, and any relevant diagnostic reports
    d. Recent images of lesion (e.g., colour photograph(s), optical coherence tomography, autofluorescence imaging, ultrasound) and, if tumour growth is suspected, the oldest available images. Patients presenting to a GP should therefore be directed to their local optometrist for imaging, tentative diagnosis and, if necessary, referral to an ophthalmologist.
    e. Special needs and preferences of patient (e.g., interpreter)
6. Within 24 hours:
    a. Send general practitioner and patient confirmation of referral (e.g., copy of referral letter)
    b. Give patient a number to phone if appointment letter is not received in 2 weeks
    c. Ensure that referral has been received by hospital

Royal College of Ophthalmologists guidelines: https://www.rcophth.ac.uk/wp-content/uploads/2021/01/Referral-Pathways-for-Adult-Ocular-Tumours-Feb-2021.pdf
College of Optometrists guidelines: https://www.college-optometrists.org/guidance/clinical-management-guidelines/pigmented-fundus-lesions.html
NHS: Delivering cancer waiting times. A good practice guide: https://www.england.nhs.uk/wp-content/uploads/2015/03/delivering-cancer-wait-times.pdf