

The Creed of Triage

This Is the Way
To Sort. To Escalate. To Protect Vision.

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The Mission

Recognize true emergencies
Apply structured framework
Identify red flags
Escalate using correct channel



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To Sort, Not to Diagnose

Your job is not to be right.
Your job is to be safe.



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The Triage Code

Risk
Time
Escalation



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The Four Tiers of Urgency

Emergent – Immediate
Urgent – Same Day
Semi-Urgent – 24–72h
Routine – Next Available

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The Six Questions

When did it start?
Painful or painless?
Vision change?
Trauma?
Contact lenses?
Recent surgery?

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The Vision Algorithm

Monocular vs Binocular
Painful vs Painless
Sudden vs Progressive

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Ophthalmic vs Neurologic

Monocular vision loss → usually ocular
Binocular vision loss → think neurologic
Binocular diplopia → think neurologic
Neuro questions: weakness/numbness, facial droop, speech change, severe headache, coordination change, field cut
Call 911: acute neuro symptoms or suspected stroke/TIA. Send to stroke center (not clinic).

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Ocular Trauma:

Ask: Mechanism (blunt / penetrating / high-velocity / chemical)
Time of Injury
Vision change
Pain
Last PO intake
Immediate: chemical exposure; suspected open globe; severe blunt trauma + ↓vision/diplopia
Same day: significant abrasion pain; persistent photophobia; any vision change after injury

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Post-Op, Post-Injection:

Always clarify:

- Procedure (surgery/laser/injection),
- Which eye
- When
- Pain
- Vision change

Immediate: pain + ↓vision; severe headache + nausea; sudden vision loss; increasing redness + vision decline; new floaters after injection

Same day: worsening blur; increasing light sensitivity; new/worsening floaters; concern after laser, anyone who prefers to be seen

Do not assume "normal"—escalate first, reassure later.

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Retinal Detachment:

- Flashes
- Floaters
- Curtain/shadow
- Field loss
- Symptom Onset

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Contact Lens Ulcer:

- Contact lens wearer + pain/redness
- Photophobia
- Vision change

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Precision in Language

- Avoid vague terms (“eye problem”, “blurry”)
- Document exact onset and patient words
- Use specific escalation phrasing

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The Escalation Script

- “I am concerned about ...”
- “This could represent ...”
- “I recommend evaluation today.”

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Choose the Right Channel

- Emergent – Interrupt clinic visit
- Urgent – Direct call / SecureChat with confirmation
- Semi-Urgent –SecureChat with confirmation
- Routine –Inbox / email
- If it’s urgent enough to worry about, it’s urgent enough to interrupt.

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Documentation Discipline

Document exact symptom language and timing

Record red flags explicitly

Avoid vague descriptors

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Case 1

65-year-old: floaters +flashes + shadow/curtain

Additional Q's?

What tier?

What channel?

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Case 2

POD 1 cataract: pain + nausea + blurred vision

Additional Q's?

What tier?

What channel?

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Case 3

POD 4 CEIOL: pain + redness + light sensitivity + blurred vision
(can't see 2 fingers)

Additional Q's?
What tier?
What channel?

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Case 4

POM 6 CEIOL: floaters + flashing lights + no pain

Additional Q's?
What tier?
What channel?

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First Line of Defense

You are the first clinical filter between a patient and preventable vision loss.

Triage is not clerical work.

It is clinical judgment.

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The Closing Creed

To sort.
To escalate.
To protect vision.

Your job is not to be right.
Your job is to be safe.

This is the way.


