The Creed of Triage

This Is the Way

To Sort. To Escalate. To Protect Vision.

Oregon Academy of Ophthalmology
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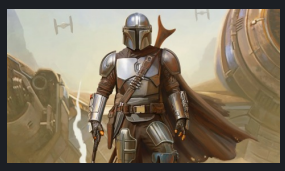

1

The Mission

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

2

To Sort, Not to Diagnose

Your job is not to be right.

Your job is to be safe.

3

The Triage Code

Risk
Time
Escalation

4

The Four Tiers of Urgency

Emergent – Immediate

Urgent – Same Day

Semi-Urgent – 24–72h

Routine – Next Available

5

The Six Questions

When did it start?

Painful or painless?

Vision change?

Trauma?

Contact lenses?

Recent surgery?

6

The Vision Algorithm

Monocular vs Binocular

Painful vs Painless

Sudden vs Progressive

7

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).

8

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

9

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.

10

Retinal Detachment:

Flashes

Floaters

Curtain/shadow

Field loss

Symptom Onset

11

Contact Lens Ulcer:

Contact lens wearer + pain/redness

Photophobia

Vision change

12

Precision in Language

Avoid vague terms (“eye problem”, “blurry”)

Document exact onset and patient words

Use specific escalation phrasing

13

The Escalation Script

“I am concerned about …”

“This could represent …”

“I recommend evaluation today.”

14

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.

15

Documentation Discipline

Document exact symptom language and timing

Record red flags explicitly

Avoid vague descriptors

16

Case 1

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

Additional Q's?
What tier?
What channel?

17

Case 2

POD 1 cataract: pain + nausea + blurred vision

Additional Q's?
What tier?
What channel?

18

Case 3

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

Additional Q's?
What tier?
What channel?

19

Case 4

POM 6 CEIOL: floaters + flashing lights + no pain

Additional Q's?
What tier?
What channel?

20

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.

21

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.

22