Clinical Prioritisation Criteria (CPC)

CPC End-user Testing

Sunshine Coast

November 2015

CPC Testing Support Pack – Sunshine Coast

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For more information contact:
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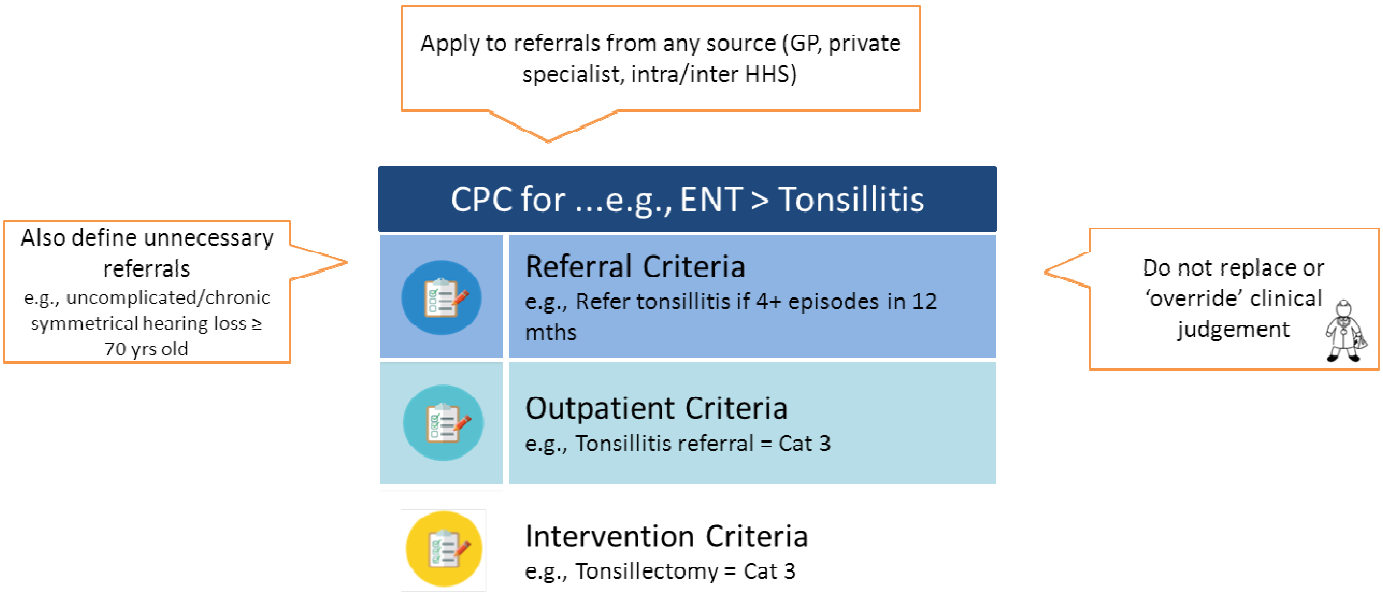
Introduction

What are CPC?

Transparent minimum criteria, applied statewide, to support equitable and appropriate prioritisation of access to public medical specialist services (first specialist outpatient appointment and intervention).



CPC Testing - overview

CPC Testing will identify any operational concerns prior to state-wide implementation. Specifically, it will:

1. Assess the possible impacts of CPC on service activity (impact assessment)
2. Assess the usability of CPC (quality assurance).

The end product of CPC embedded in an interoperable IT platform is not being tested (it has not been built); however, testing of the CPC format (flow) as it currently stands will assist in designing the IT platform, and will inform further decisions around the statewide roll out of CPC.

The **Sunshine Coast Region** is testing CPC for Gynaecology, Orthopaedics and Urology in 18 General Practices. The most commonly referred conditions have been included for each speciality as well as what should be considered an emergency referral to an Emergency Department.

CPC Testing begins **2 November 2015** and ends on **27 November 2015 (4 weeks).**

Please Note: This document is not the final format of the CPC, and is only for the purposes of testing.

General information

Expected benefits

- Improve equity & transparency of access to public medical specialist care for all Queenslanders.
- Reduce uncertainty around if and when patients should see a medical specialist in the public health system.
- Improve communication and expectations between patients, general practitioners, and the public health system.
- Over time, reduce inefficiencies in accessing the right healthcare, as patients will not be placed on waiting lists unnecessarily.

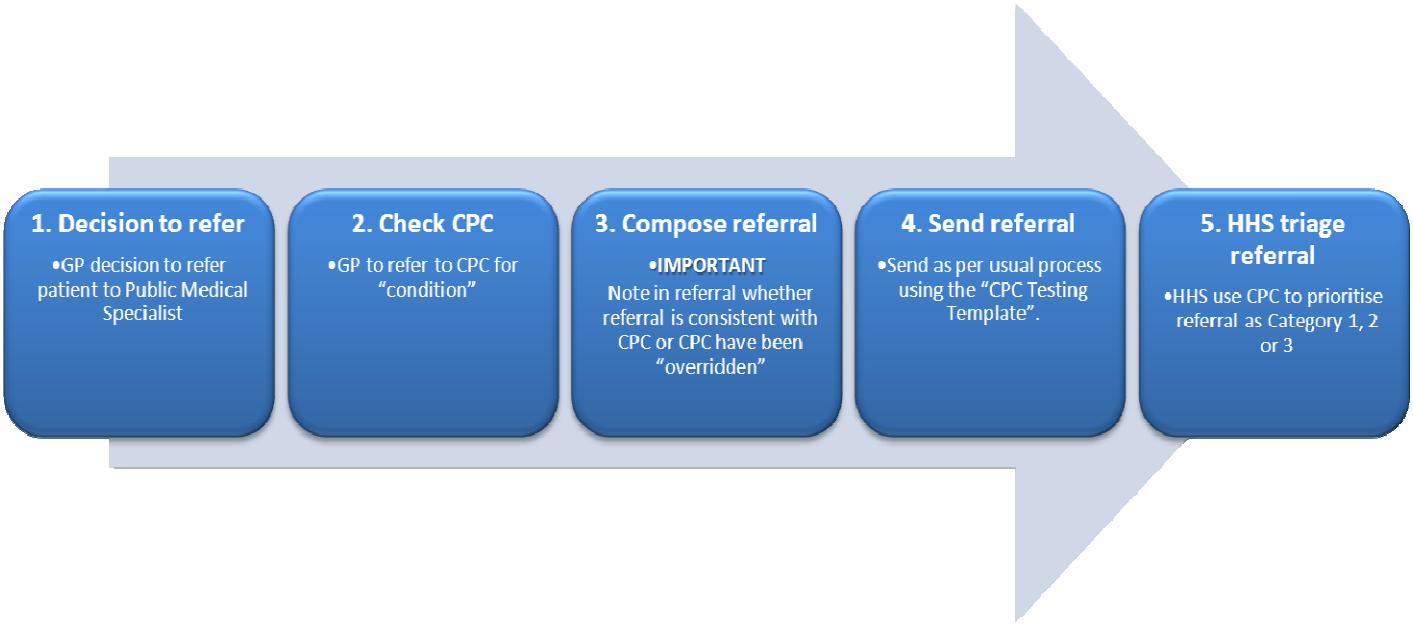
Other key messages:

- CPC do NOT replace clinical judgment and will not determine the most appropriate treatment or health pathway. Doctors will continue to make these decisions.
- CPC were developed by leading clinical experts in Queensland.
- CPC is a statewide project. CPC for approximately 10 medical speciality services are being developed every 6 months. No CPC have been implemented yet.
- 18 General Practices are anticipated to be involved in CPC testing in your region.
- Application of CPC supports clinically appropriate prioritisation of the patient. In Queensland, Category 1, 2 and 3 specify the clinically recommended timeframe for first specialist outpatient appointment.
- The patient's appointment should occur within this timeframe; however, this cannot be guaranteed.
- Consideration has been given to the issue of patient consent during testing; however, it was deemed unnecessary for a number of reasons, including that clinicians continue to exercise clinical judgement on the necessity of the referral.

Instructions

How to use CPC during CPC Testing

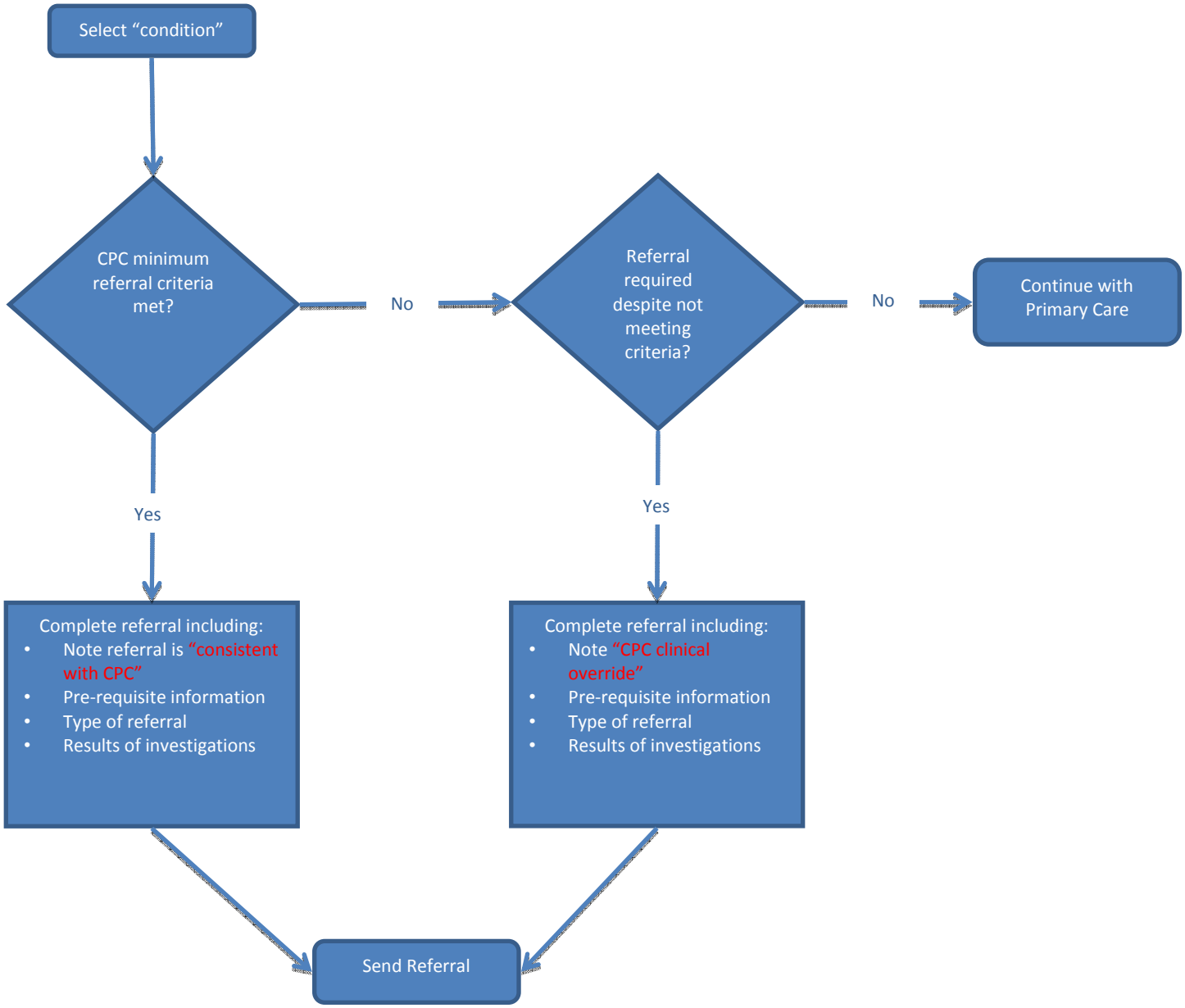
1. If you decide a patient referral to a specialist outpatient clinic is required, please consult the CPC for the relevant "condition" (currently organised by specialty) and follow the instructions.
2. Ask "are all the minimal referral criteria met?" If not,
    a. continue with primary care; or
    b. override the CPC and continue to make a referral.
3. When composing the referral it is essential to note that the CPC have been applied, please indicate
    a. For referral made via the **CPC testing template** please tick the box that reads "consistent with CPC" or "CPC clinical override"
    b. for all other referrals, please refer as usual.
4. Continue to send referrals as usual during CPC testing.
5. HHS staff will use CPC to review referral information and for the purposes of clinically prioritising patients.



Diagnostic tests marked with an asterisk (*) may incur a cost to the patient or access may be limited, particularly in rural and remote areas. Please indicate in the referral if the patient is unable to access the service due to financial hardship or where they live.

In such cases, access to these services will be coordinated through the public system. Once the service is undertaken, if the patient meets the minimum criteria they will be scheduled to see the specialist; if the patient does not meet the minimum criteria they will be returned to the referring practitioner for management.

Decision tree for applying CPC at point of referral



Getting Help

On-site support

Referring Practitioners

Your first point of contact is your Practice Manager (if applicable).

Otherwise please contact your local Primary Health Network support officer.

Hospital and Health Service

Your first point of contact is your General Practice Liaison Officer (GPLO)

Dr Sandra Peters
Phone: 0427 625 607
Email: Sandra.Peters@health.qld.gov.au

CPC Team support

For any advice or information during CPC testing please do not hesitate to contact the CPC team:

Email: CPC@health.qld.gov.au
Phone: (07) 3234 1813 – Monday to Friday between 8am and 5pm.

Feedback

You will be asked to complete a feedback survey after CPC testing. Survey findings will inform statewide implementation strategies by:

- identifying any barriers or problems you experienced when applying CPC
- collecting your views on the CPC format, ease of use, look and feel.
- assessing how CPC impacted your referral/categorisation decisions, or not?

The survey can be completed online by clicking on the relevant link below:

For referring practitioners:	**https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_GPs**

For Hospital & Health Service staff:	**https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_HHS**

If you are unable to access the online survey, please contact the CPC team, and a hardcopy will be provided to you.

Please complete the feedback survey between 27 November 2015 and 8 December 2015.

Draft Gynaecology Clinical Prioritisation Criteria

In-scope for Gynaecology outpatient services

The following conditions are proposed to be considered under the Gynaecology CPC, 2015:

• Abnormal pap smear/ cervical dysplasia • Heavy Menstrual Bleeding (HMB) • Post-menopausal bleeding • Ovarian cyst/ pelvic mass • Post-coital bleeding • Cervical polyp • Intermenstrual bleeding	• Amenorrhoea (Primary/secondary) • Pelvic pain • Prolapse • Fibroids • Endometriosis (Known or suspected) • Infertility (and refer to private specialists to avoid delay)

In-scope paediatric conditions

The CPC PAG did not recommend any paediatric conditions for consideration at this stage; however, paediatric conditions may be added as the CPC is reviewed and updated.

CPC for the general paediatric speciality are also planned to be developed. The PAG will also advise on CPC implementation and how paediatric referrals can be optimally managed.

Out-of-scope for Gynaecology outpatient services

It is proposed that the following are not routinely provided in a public Gynaecology service (exceptions can be made where clinically indicated):

Exclusion criteria include the following: • elective cosmetic surgery eg.labiaplasty • elective termination of pregnancy • IVF services	Recommend referral to Family Planning Queensland or Women's Health speciality primary care providers for the following: • contraception eg. Implanon • routine Mirena®/IUD insertion for contraception • primary menopausal care

• reversal of tubal ligation • elective tubal ligation but will be accepted as a Category 3, if : – patient cannot use/trialled other contraceptive methods – patient does not want to pass on any genetic disorders or disabilities – indicated for women suffering from medical or obstetric conditions that would contraindicate future pregnancy.	• screening pap smear • postnatal check-up

Emergency referrals

It is proposed that the following conditions should be sent directly to the emergency department:

• acute pelvic pain • severe vaginal bleeding • hyperemesis gravidarum • ascites, secondary to known underlying gynaecological oncology • post-operative complications within 6 weeks including wound infection, wound breakdown, vaginal bleeding/discharge, retained products of conception post op, abdominal pain • abscess intra pelvis or pelvic inflammatory disease (PID) • vulva or vaginal lacerations / haematoma • bartholin's abscess • penetrating injuries	• significant or uncontrolled bleeding • severe pain • severe infection • acute trauma • ectopic pregnancy • inevitable and / or incomplete abortion • ruptured haemorrhagic ovarian cyst • torsion of uterine appendages • urinary retention • molar pregnancy

Referral and Outpatient criteria

The information to be included in this section of the CPC is intended to assist:

- GPs and other referring practitioners to identify the point at which a patient may benefit most from referral to medical or surgical specialist services, the information necessary to support the referral and how quickly the patient may be seen.
- Appropriate HHS staff to make transparent and equitable decisions on when referrals should be accepted and the timeframe within which a patient should be seen.

Gynaecology — Abnormal pap smear / cervical dysplasia

Minimum Referral Criteria

Cat 1	· high-grade squamous intraepithelial lesion (HSIL) on pap smear · any glandular cervical lesion suspected on pap smear · SCC cervix	Cat 2	• low-grade squamous intraepithelial lesion (LSIL) x 2 on pap smears 12 months apart • LSIL >30 years of age (No pap smear in past 2 – 3 years)	Cat 3	• N/A

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO → **Primary Care Options**

1. Pre-Requisite Information

- General referral information
- history of previous treatment
- history of any abnormal bleeding (ie. post-coital and intermenstrual) or abnormal discharge
- HPV vaccination history (if available)
- smoking status and history
- history of Immunosuppressive therapy

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- current pap smear and history of previous abnormal pap smears
- +/- STD screen

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

Ÿ unsatisfactory smear – repeat in 6-12 weeks after correction of problem

Ÿ consider using Oestrogen cream +/- liquid cytology in post-menopausal patients

Ÿ LSIL with previous normal pap smear or LSIL after LLETZ – repeat pap smear in 12 months

Useful guidelines

· 2005 NHMRC guidelines - these guidelines are currently under review

Gynaecology — Amenorrhoea (primary/ secondary)

Minimum Referral Criteria

Cat 1	· N/A	Cat 2	· N/A	Cat 3	· Primary amenorrhoea - is defined as the absence of menses at age 16 years in the presence of normal growth and secondary sexual characteristics, and 14 in the absence of secondary sexual characteristics · Secondary amenorrhea - absence of menses for more than six months after the onset of menses

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

YES ←

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

1. Pre-Requisite Information

- general referral information
- duration of amenorrhoea (ie. >6 months)
- weight/body mass index

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- Beta HCG
- FSH
- LH
- Prolactin
- Oestradiol
- TSH

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

Ÿ Address excessive exercise or dieting
Ÿ Address obesity if relevant
Ÿ Address any significant stress or anxiety
Ÿ Review medications if relevant (eg. antipsychotics, metoclopramide)

Useful information

Exclude pregnancy and prolactinoma

Gynaecology — Cervical polyp

Minimum Referral Criteria

Cat 1	· cervical polyp with abnormal pap smear	Cat 2	• cervical polyps in post-menopausal women with normal pap smear	Cat 3	• cervical polyps in pre-menopausal women

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- general referral information
- findings of speculum examination

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- +/- pelvic ultrasound (TVS preferable) if available*
- current pap smear

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

Ÿ small endocervical polyps (<2cm) in premenopausal women with a normal pap smear can be avulsed and sent for histology

Ÿ cervical polyps in post-menopausal women have a higher risk of malignancy

Gynaecology — Endometriosis (known or suspected)

Minimum Referral Criteria

Cat 1	· N/A	Cat 2	· likelihood of inpatient admission · multiple Emergency Department presentations · endometriomas on USS · associated bowel or bladder disturbance	Cat 3	· chronic pain · those not responding to suppression of menstrual cycle

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- full previous treatment including operations and medical trialled if known
- history of pain and menstrual diary
- symptoms
- dysmenorrhoea
- deep dyspareunia
- dyschezia
- history of sub-fertility

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*

SEND REFERRAL

Primary Care Options

refer to local care pathway

OR

Ÿ suppression of menstrual cycle with oral contraceptive pill / Implanon / Depo-Provera / Mirena®. 6 month trial appropriate prior to referral

Useful information

Ÿ NICE in development [GID-CGWAVE0737] Anticipated publication date: May 2017

Minimum Referral Criteria

Cat 1	· organ obstruction, impairment or · suspicion of degeneration or malignancy · heavy menstrual bleeding (HMB) with anaemia (Hb<85) or requiring transfusion · fibroid prolapse through cervix	Cat 2	· pressure symptoms (such are ureteric impingement) · HMB with anaemia · abdominal discomfort	Cat 3	• Heavy Menstrual Bleeding

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- symptoms
- heavy menstrual bleeding
- dragging sensation
- urinary frequency

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- Full blood count (FBC)

Primary Care Options

refer to local care pathway

OR

Ÿ if asymptomatic with normal menstrual pattern and normal Hb, no need for referral

Ÿ

SEND REFERRAL

Gynaecology — Heavy Menstrual Bleeding (HMB)

Minimum Referral Criteria

Cat 1	· suspicion of malignancy · heavy menstrual bleeding (HMB) requiring blood transfusion · heavy menstrual bleeding (HMB) with anaemia (Hb<85)	Cat 2	· heavy menstrual bleeding (HMB) with anaemia (Hb>85)	Cat 3	• heavy menstrual bleeding (HMB) without anaemia not responding to treatment

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- brief description of periods and previous treatment

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- current pap smear.
- FBC +/- Iron studies
- TSH if symptomatic of thyroid disease

SEND REFERRAL

Primary Care Options

refer to local care pathway

OR

Consider increased risk of hyperplasia or malignancy if

Ÿ endometrial thickness greater than 12mm (transvaginal ultrasound ideally day 4-7) (CancerAustralia 2011)

Ÿ weight >90kg

Ÿ polycystic ovary syndrome (PCOS) / diabetes / unopposed oestrogen

Ÿ age >45yrs

Ÿ intermenstrual or post-coital bleeding

Treatment:

Ÿ oral contraceptive pill (OCPs)

Ÿ non-steroidal anti-inflammatory drugs (NSAIDS)

Ÿ Tranexamic acid

Ÿ Mirena® Intrauterine System (IUS)

Ÿ oral progestogens (NHC Guidelines)

Gynaecology — Infertility

Minimum Referral Criteria

Cat 1	· N/A	Cat 2	· N/A	Cat 3	• all referrals for infertility *(Definition:- Infertility is the failure to achieve pregnancy after 12 months or more of unprotected intercourse)*

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

1. Pre-Requisite Information

- General referral information
- history of
  - o previous pregnancies
  - o sexually transmitted diseases (STDs) and pelvic inflammatory disease (PID)
  - o surgery
  - o endometriosis
  - o other medical conditions
- include the following information about partner
  - o age and health
  - o reproductive history
- testicular conditions

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- current pap smear.
- FBC +/- Iron studies
- TSH if symptomatic of thyroid disease

SEND REFERRAL

Primary Care Options

refer to local care pathway
OR

- Ÿ smoking cessation
- Ÿ optimise health
- Ÿ achieve optimal weight BMI 20 – 30
- Ÿ Folic Acid 0.5mg/day

Useful information

- Ÿ hysterosalpingography (HSG) or saline infusion (HSG) if history suggestive of blocked fallopian tubes (if available) – to assess tubal patency in view of potential long wait.
- Ÿ history of marijuana use (including partner) – *make reference if appropriate*
- Ÿ IVF not available in public hospitals
- Ÿ Testosterone and free androgen index test for those likely to have Polycystic Ovarian Syndrome (PCOS)

Gynaecology — Intermenstrual bleeding

Minimum Referral Criteria

Cat 1	· suspected malignancy – cervical or endometrial · abnormal pap smear (HSIL or glandular lesion) · endometrium >12mm on pelvic ultrasound scan (transvaginal ultrasound ideally day 4-7) (CancerAustralia 2011)	Cat 2	· intermenstrual bleeding not due to hormonal contraception · abnormal pap smear (LSIL)	Cat 3	• bleeding related to hormonal contraception that is not responding to contraception manipulation

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO

1. Pre-Requisite Information

- general referral information
- findings of speculum examination

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- +/- pelvic ultrasound (TVS preferable) if available*
- current pap smear
- high vaginal swab (HVS)
- endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA (Nucleic Acid Amplification test) (RANZCOG 2015)

SEND REFERRAL

Primary Care Options

refer to local care pathway

Useful information

Reference Material

Investigation of intermenstrual and postcoital bleeding (RANZCOG 2015)

Gynaecology — Ovarian cyst / pelvic mass

Minimum Referral Criteria

Cat 1	· suspicious features such as solid areas, papillary projections, septations, abnormal blood flow, bilaterally or ascites · cyst > 12cm · elevated Ca125 and cyst >5cm or post-menopausal patient · pre-pubertal patient.	Cat 2	• persistent cyst >5cm on 2 pelvic ultrasound scans 6 weeks apart. • persistent pain • complex cyst (haemorrhagic, endometriotic or dermoid)	Cat 3	• hydrosalpinx

YES ← **Does the Patient meet the Minimum Referral Criteria?** → **NO**

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- history including pain and other symptoms

YES ← **Please insert 'Criteria Override' into referral**

Do you still wish to refer patient and override Minimum Criteria?

NO →

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- Ca125 blood tests

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

Ÿ if cyst simple or haemorrhagic corpus luteal cyst and <5 cm repeat scan in 6 – 12 week

Ÿ if recurrent cysts, consider combined oral contraceptive pill (COCP) or Implanon.

Ÿ if suspected torsion, refer Emergency Department.

Useful information

· ask for family history of breast and ovarian cancer

Ÿ

Gynaecology — Pelvic pain

Minimum Referral Criteria

Cat 1	· N/A	Cat 2	· likelihood of inpatient admission · multiple Emergency Department presentations o abnormal changes on ultrasound - presence of endometriomas / fixed retroverted uterus	Cat 3	· pelvic pain not responding to primary care

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO → **Primary Care Options**

1. Pre-Requisite Information

- general referral information
- general referral information (see *Appendix 3*)
- history of pain
- severity and duration
- cyclical nature
- dysmenorrhoea
- differentiate from gastrointestinal pain
- history of previous sexual abuse, PID

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- pelvic ultrasound (TVS preferable) if available*
- current pap smear
- high vaginal swab (HVS)
- endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA (Nucleic Acid Amplification test) (RANZCOG 2015)
- mid-stream urine (MSU)

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

- Ÿ treat infection if present
- Ÿ simple analgesia
- Ÿ suppress menstrual cycle with oral contraceptive pill / Implanon / Depo-Provera / Mirena®
- Ÿ treat dysmenorrhoea with non-steroidal anti-inflammatory drugs (NSAID) or combined oral contraceptive pill (COCP)

Useful information

- *associated cyclical bladder, bowel symptoms*

Gynaecology — Post coital bleeding

Minimum Referral Criteria

Cat 1	· suspected malignancy · squamous-cell carcinoma (SCC), High-grade squamous intraepithelial lesion (HSIL), glandular lesion on pap smear	Cat 2	· post-coital bleeding with LSIL or normal pap smear result	Cat 3	• N/A

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO

1. Pre-Requisite Information

- general referral information
- findings of speculum examination

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- +/- pelvic ultrasound (TVS preferable) if available*
- current pap smear
- high vaginal swab (HVS)
- endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA (Nucleic Acid Amplification test) (RANZCOG 2015)

SEND REFERRAL

Primary Care Options
refer to local care pathway

Useful information
Reference Material
Investigation of intermenstrual and postcoital bleeding (RANZCOG 2015)

Gynaecology

Post-menopausal bleeding
(Vaginal bleeding more than 12 months following last menstrual period)

Minimum Referral Criteria

Cat 1	· endometrial thickness >4mm · cervical polyps · suspicion of malignancy · focal endometrial lesion	Cat 2	· endometrial thickness ≤4mm	Cat 3	• N/A

YES ↓

Does the Patient meet the Minimum Referral Criteria?

NO ↓

Please insert criteria into referral

1. Pre-Requisite Information
- general referral information
- history of hormone replacement therapy (HRT) use

YES ←
Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

Primary Care Options
refer to local care pathway

2.Reason for Request *indicate on the referral*
- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3.Insert results for required investigations in referral
- current pap smear
- pelvic ultrasound (TVS preferable) if available*

→ **SEND REFERRAL**

Gynaecology — Prolapse

Minimum Referral Criteria

Cat 1	· ulcerated uterine procidentia · urinary obstruction	Cat 2	· severe prolapse with obstructive symptoms · difficulty voiding · recurrent urinary tract infections (UTI's) o +/- significant residuals on bladder scanning	Cat 3	· prolapse other than category 1 or category 2 · urinary incontinence · obstructive defecation

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- general referral information (see Appendix 3)
- symptoms
  - o protruding lump
  - o dragging sensation
  - o difficulty with defecation / micturition
  - o incontinence
- past obstetric and gynaecological history

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· mid-stream urine (MSU) and microscopy, culture and sensitivity (M/C/S)
· pelvic ultrasound (TVS preferable) if available

SEND REFERRAL

Primary Care Options

· refer to local care pathway

OR

· prolapse – consider pessary.
· stress incontinence – physio for pelvic floor exercises for 3 months prior to referral
· urinary urgency – mid-stream urine (MSU) and microscopy, culture and sensitivity (M/C/S)
· bladder retraining
· consider trial of anticholinergics
· advise weight loss as necessary, reduce caffeine intake and optimise general health
· address constipation
· consider topical oestrogen in post-menopausal women

Draft Orthopaedic Clinical Prioritisation Criteria

In-scope for Orthopaedic outpatient services

The following conditions are proposed to be considered under the Orthopaedic CPC, 2015:

- Upper limb
  - shoulder/elbow
    - osteoarthritis
    - pain/stiffness including frozen shoulder
    - rotator cuff tears/tendinopathy
    - AC joint problems
    - shoulder/elbow instability
    - recurrent dislocation of shoulder
  - wrist and hand
    - stenosing tenosynovitis
    - Dupuytrens contracture
    - basal thumb arthritis
    - ganglia
    - painful/stiff wrist
    - upper limb peripheral nerve compression
    - pain and instability in hind foot
- Spine/Back Pain
  - arthritis
  - disc related
  - neoplastic and infection
- fractures
  - upper limb fractures
  - hand fractures
  - lower limb fractures
  - spinal fractures
- Lower limb
  - hip and knee
    - hip pain
    - acute knee injury
    - chronic knee pain
  - foot and ankle
    - arthritis
    - heel pain
    - Achilles tendon pathology
    - pain/deformity in forefoot

In-scope paediatric conditions

The CPC PAG did not recommend any paediatric conditions for consideration at this stage; however, paediatric conditions may be added as the CPC is reviewed and updated.

Out-of-scope for Orthopaedic outpatient services

It is proposed that the following are not routinely provided in a public Orthopaedic service (exceptions can be made where clinically indicated):

- Aesthetic or cosmetic surgery

Emergency referrals

It is proposed that the following conditions should be sent directly to the emergency department:

- Acute spinal cord symptoms
- Acute cauda equina
- Acute cervical myelopathy
- Acute back or neck pain secondary to neoplastic disease or infection
- Suspected open fracture
- Fractures requiring manipulation or operation
- Suspected acute bone or joint infection
- Acute high energy fractures with/without neurological abnormality
- High energy spine injuries
- Osteoporotic / pathological fractures new abnormal neurology
- Suspected infection or sudden pain in arthroplasty
- If joint infection is suspected refer immediately to emergency or contact the orthopaedic registrar on call. **Do not commence antibiotics unless delay to specialist review is likely**
- Joint dislocations
- Acute peripheral nerve injury
- Suspected acute compartment syndrome in a limb

Referral and Outpatient criteria

The information to be included in this section of the CPC is intended to assist:

- GPs and other referring practitioners to identify the point at which a patient may benefit most from referral to medical or surgical specialist services, the information necessary to support the referral and how quickly the patient may be seen.
- Appropriate HHS staff to make transparent and equitable decisions on when referrals should be accepted and the timeframe within which a patient should be seen.

Orthopaedics — Foot and Ankle - Achilles tendon pathology and rupture

Minimum Referral Criteria

Cat 1	· if acute rupture suspected refer to emergency department or local fracture clinic · if delayed presentation of rupture (greater than 3 weeks) refer local fracture clinic.	Cat 2	· a tender, nodular swelling	Cat 3	· functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO

1. Pre-Requisite Information

- General referral information
- rate of deterioration of the condition
- aggravating and relieving factors
- pain assessment –waking up at night, analgesic consumption
- interference with ADL and working ability
- neurological deficit

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray - AP and lateral ankle/foot
- ultrasound (not required for Achilles rupture if examination confirms)

SEND REFERRAL

Primary Care Options

- refer to local care pathway
  or
- analgesia/NSAIDs as appropriate
- physiotherapy/podiatry (where available)
- heel cups/heel raise (where available)
- abstention from the activities that caused the symptoms

Useful information, where available

- treatment carried out to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports (if available)

Orthopaedics — Foot and Ankle - Arthritis

Minimum Referral Criteria

Cat 1	· skin ulceration secondary to deformity or pressure (High Risk Foot Clinic – where available)	Cat 2	· presence of avascular necrosis · associated with diabetic peripheral neuropathy	Cat 3	· functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- pain assessment –waking up at night, analgesic consumption
- aggravating and relieving factors
- rate of deterioration of the condition
- interference with Active Daily Living (ADL) and working ability
- nerve irritation signs (Tinels sign or hyperaesthesia)
- neurological deficit

YES ←

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· x-ray - AP and lateral ankle/foot including weight bearing/standing views

SEND REFERRAL

Primary Care Options

Ÿ refer to local care pathway
or
Ÿ analgesia/NSAIDs (as appropriate)
Ÿ consider steroid injection (as appropriate)
Ÿ physiotherapy
Ÿ podiatry
Ÿ activity modification
Ÿ footwear advice/walking aids (where available)
Ÿ therapeutic massage
Ÿ weight control management (as appropriate)

Useful information, where available

Ÿ treatment carried out to date (including insoles and physiotherapy)
Ÿ High risk foot clinic or podiatrist reports (if available)

Orthopaedics — Foot and Ankle – Heel Pain

Minimum Referral Criteria

Cat 1	· if associated with trauma, infection, suspected fracture or ulceration refer to fracture clinic	Cat 2	· if associated with diabetic peripheral neuropathy	Cat 3	· functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

YES ← **Please insert 'Criteria Override' into referral**

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

1. Pre-Requisite Information

Ÿ General referral information
Ÿ rate of deterioration of the condition
Ÿ aggravating and relieving factors
Ÿ pain assessment – waking up at night, analgesic consumption
Ÿ interference with ADL and working ability
Ÿ nerve irritation signs (Tinels sign or hyperaesthesia)
Ÿ neurological deficit

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· x-ray - AP and lateral ankle/foot including weight bearing/standing views

SEND REFERRAL

Primary Care Options

Ÿ refer to local care pathway
or
Ÿ analgesia/NSAIDs as appropriate
Ÿ steroid injections for plantar fasciitis under the trigger point
Ÿ NB: Ibuprofen is effective in the 'reactive'(acute/acute-on-chronic) stage of tendinopathy
Ÿ physiotherapy/podiatry (where available)
Ÿ heel cups/raise (where available)

Useful information, where available

Ÿ treatment carried out to date (including insoles and physiotherapy)
Ÿ High risk foot clinic or podiatrist reports (if available)

Orthopaedics — Heel and Foot - Pain / deformity in forefoot and hind foot

Minimum Referral Criteria

Cat 1	· if associated with trauma, infection, suspected fracture or ulceration refer to fracture clinic	Cat 2	· if associated with diabetic neuropathy threatened ulceration	Cat 3	· functional impairment a pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

1. Pre-Requisite Information

- Ÿ General referral information
- Ÿ rate of deterioration of the condition
- Ÿ aggravating and relieving factors
- Ÿ pain assessment –waking up at night, analgesic consumption
- Ÿ interference with ADL and working ability
- Ÿ neurological deficit
- Ÿ nerve irritation signs

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray - AP and lateral ankle/foot including weight bearing/standing views
-

SEND REFERRAL

Primary Care Options

- Ÿ refer to local care pathway
  or
- Ÿ analgesia/NSAIDs as appropriate
- Ÿ check tibialis posterior
- Ÿ modification footwear/arch supports (where available)
- Ÿ physiotherapy/podiatry (where available)
- Ÿ orthoses (where available)
- Ÿ weight loss management
- Ÿ consider ultrasound-guided steroid injection for Morton's neuroma/intermetatarsal bursa (as appropriate)

Useful information, where available

- Ÿ treatment carried out to date (including insoles and physiotherapy)
- Ÿ High risk foot clinic or podiatrist reports (if available)

Orthopaedics — Fractures – Hand Fractures

Minimum Referral Criteria

Cat 1	· undisplaced fractures · fractures that have been reduced satisfactorily	Cat 2	· fracture delayed union or non-union · mal-union affecting function	Cat 3	· mal-union – normal function

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

Ÿ General referral information
Ÿ previous orthopaedic conditions and operations
Ÿ date, time, mechanism, severity or evolution of injury
Ÿ other joint involvement
Ÿ treatment to date (cast, splint etc)

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· x-ray results (instruct patient to bring imaging films/results to clinic appointment)

SEND REFERRAL

Primary Care Options

Ÿ refer to local care pathway
or
Ÿ assess and document neurovascular status
Ÿ check x-ray post manipulation (if applicable)
Ÿ immobiliser or plaster cast (as appropriate)
Ÿ acute fractures will be assessed by fracture clinic within 2 weeks

Useful information, where available

Ÿ do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar on-call.
Ÿ please refer early as treatment may change with a delayed referral
Ÿ summarise treatment to date

Orthopaedics — Fractures – Lower limb fractures

Minimum Referral Criteria

Cat 1	· undisplaced fractures · fractures that have been reduced satisfactorily	Cat 2	· fractures delayed or non-union · mal-union affecting function	Cat 3	· mal-union not affecting function

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

Ÿ General referral information
Ÿ date, time, mechanism, severity or evolution of injury
Ÿ treatment to date (cast, splint etc.)

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· x-ray results (instruct patient to bring imaging films/results to clinic appointment)

Primary Care Options

Ÿ refer to local care pathway
Ÿ or
Ÿ assess and document neurovascular status
Ÿ check x-ray post manipulation (if applicable)
Ÿ immobiliser or plaster cast (as appropriate)
Ÿ acute fractures will be assessed by fracture clinic within 2 weeks

Useful information, where available

Ÿ do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar

SEND REFERRAL

Orthopaedics

Fractures – Spinal fractures
(Acute osteoporotic / pathological fractures not requiring admission for pain relief)

Minimum Referral Criteria

Cat 1	· osteoporotic / pathological fractures suspected malignancy or chronic infection · acute infection or abscess to Emergency Department	Cat 2	· osteoporotic / insufficiency fracture with ongoing pain	Cat 3	· N/A

Does the Patient meet the Minimum Referral Criteria?

YES ↓

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- date, time, mechanism, severity or evolution of injury
- treatment to date (cast, splint etc)

2. *Reason for Request* *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray results (instruct patient to bring imaging films/results to clinic appointment)

SEND REFERRAL

NO ↓

Do you still wish to refer patient and override Minimum Criteria?

YES → **Please insert 'Criteria Override' into referral**

NO ↓

Primary Care Options

- refer to local care pathway
  or
- pain management,
- physiotherapy
- OPSC pathways– (where available)
- medical management of osteoporosis
- treatment of underlying cause

Useful information, where available

- do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar

Orthopaedics — Fractures – Upper limb fractures

Minimum Referral Criteria

Cat 1	· undisplaced fractures · fractures that have been reduced satisfactorily	Cat 2	· fractures delayed or non-union · mal-union affecting function	Cat 3	· mal-union not affecting function

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

1. Pre-Requisite Information

Ÿ General referral information
Ÿ previous orthopaedic conditions and operations
Ÿ date, time, mechanism, severity or evolution of injury
Ÿ treatment to date (cast, splint etc)
Ÿ other joint involvement

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

Ÿ x-ray results (scaphoid views only if out of plaster)
- instruct patient to bring imaging films/results to clinic appointment

SEND REFERRAL

Primary Care Options

Ÿ refer to local care pathway
or
Ÿ assess and document neurovascular status
Ÿ check x-ray post manipulation (if applicable)
Ÿ immobilise fracture limb in a sling, shoulder immobiliser or plaster cast (as appropriate)
Ÿ acute fractures will be assessed by fracture clinic within 2 weeks

Useful information, where available

Ÿ Do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar.

Orthopaedics — Hip and Knee – Acute Knee Injury

Minimum Referral Criteria

Cat 1	· locked knee · significant internal or ligamentous derangement · x-ray demonstrates fracture – refer fracture clinic or emergency department	Cat 2	· identified: o post traumatic instability o meniscal injuries o effusion · unstable patella · avascular necrosis of the tibial plateau	Cat 3	· functional impairment and ongoing pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

YES → **Please insert 'Criteria Override' into referral**

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

1. Pre-Requisite Information

- General referral information
- date, history, recurrence of injury and mechanism, severity or evolution of injury
- pain and other symptoms including haemarthrosis/effusion, locking, instability
- results of clinical ligament and meniscus tests if completed
- true locking (vs intermittent stiffness)

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- plain x-ray of knee weight bearing AP, lateral and skyline
- MRI if possible, for acute knee injury (if available)

SEND REFERRAL

Primary Care Options

- refer to local care pathway
  or
- analgesia/NSAIDs (as appropriate)
- x-ray to rule out fracture
- RICE: Rest, Ice, Compression, Elevation,
- physiotherapy and/or hydrotherapy
- activity modification/gait aid
- advice to remain active as pain allows (Get moving program/home exercise program)
- home modification and use of Adult Day Care (ADC)
- better health self-management program
- weight reduction monitoring
- avoid steroid injection

Useful information, where available

- **Do not commence antibiotics unless delay to specialist review is likely** - discuss with orthopaedic registrar on-call.
- hip and knee questionnaire (patient to complete) if available

Orthopaedics

Hip and Knee - Chronic knee pain
(e.g. osteoarthritis, patellofemoral joint pain- usually slow onset, no incident)

Minimum Referral Criteria

Cat 1	· evidence of acute inflammation for example: o haemarthrosis o tense effusion	Cat 2	· symptoms rapidly deteriorating and causing severe disability · pain in previously well-functioning arthroplasty	Cat 3	· Some functional impairment and ongoing pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- date, history, recurrence of injury and mechanism, severity or evolution of injury
- history of recurring infections
- previous joint surgery
- true locking (vs intermittent stiffness)
- results of clinical ligament and meniscus tests if completed
- pain and other symptoms including effusion, locking, instability
- BMI – obesity is associated with an increase in complications associated with surgery

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- plain x-ray of knee, weight bearing AP, lateral and skyline of both knees for arthritis
- MRI (if available)
- investigations for inflammatory arthropathy

SEND REFERRAL

Primary Care Options

- refer to local care pathway
  or
- analgesia/NSAIDs as appropriate
- physiotherapy and/or hydrotherapy
- advice to remain active as pain allows (Get moving program/ home exercise program)
- activity modification/gait aid
- home modification and use of Adult Day Care (ADC)
- better health self-management program
- dietician if BMI an issue, weight reduction monitoring
- avoid steroid injection

Useful information, where available

- treatment to date
- hip and knee questionnaire (patient to complete) if available (HipandKneeQuestionaire 2006)

Orthopaedics — Hip and Knee – Hip pain

Minimum Referral Criteria

Cat 1	· past history or suspicion of neoplasm +/- lesion on x-ray. · radiological evidence of avascular necrosis of hip in a patient <60 years	Cat 2	· Severe symptoms impairing quality of life, based on: o pain and/or disability o sleep disturbance o relating to mobility/independence o inability to undertake normal activities o reduced functional capacity or psychiatric illness o unresponsive to therapy over ≥ 2 months · pain in previously well-functioning arthroplasty · radiological evidence of avascular necrosis of hip > 60 years	Cat 3	· functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss

Does the Patient meet the Minimum Referral Criteria?

YES

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- history of recurrent infections
- previous joint surgery (THR/TKR)
- BMI – obesity is associated with an increase in complications associated with surgery
- length and severity of symptoms / degree of disability/ability/mobility
- Is the condition stable or how quickly has it deteriorated?
- examination for range of movement and fixed deformity
- level of ability to do daily activities/walking distance/ability to put on shoes

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray (AP pelvis, AP affected hip showing proximal 2/3 femur and lateral affected hip
- MRI if avascular necrosis is suspected (if available)
- Pathology: FBC, ESR, CRP

SEND REFERRAL

NO

Do you still wish to refer patient and override Minimum Criteria?

YES

Please insert 'Criteria Override' into referral

NO

Primary Care Options

- refer to local care pathway OR
- simple analgesia and NSAIDs
- physiotherapy (where available) or hydrotherapy
- activity modification
- use of a walking aid (contralateral hand)
- home modification and use of (Adult Day Care) ADC
- better health self-management program
- dietician if BMI an issue & weight reduction monitoring
- http://www.racgp.org.au/download/documents/Guidelines/Musculoskeletal/oa_algorithm.pdf

Useful information

- is surgical treatment going to get patient back to work or not?
- treatment to date
- has non-operative management been completed?
- hip and knee Questionnaire (pt to complete) if available (HHS 2006)

Orthopaedics

Shoulder and Elbows - Osteoarthritis | Shoulder pain/stiffness including frozen shoulder | Rotator cuff tears/tendinopathy | AC joint problems | Instability | recurrent dislocation of shoulder | sub-acromial impingement

Minimum Referral Criteria

Cat 1	· suspicion of malignancy · evidence of acute inflammation, for example: o haemarthrosis o tense effusion	Cat 2	· patient is <25 y/o with first-time shoulder dislocation · recurrent dislocated shoulder/shoulder instability · instability associated with structural pathology (eg Superior Labral Antero-Posterior (SLAP) lesion, large Bankart lesion) in a younger patient (<40y/o) · history of trauma suggests acute event / tear (rather than degenerative) rotator cuff tear, · shoulder adhesive capsulitis (frozen shoulder)	Cat 3	· if functional impairment and / or pain persists despite active conservative treatment such as physiotherapy or managed weight loss · acromio-clavicular (AC) Joint conditions · chronic weakness and degenerative cuff · cuff tendinopathy o sub-acromial impingement · pain/stiffness in elbow not responding to conservative treatment · elbow tendonitis

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- duration, history, recurrence of injury and mechanism, severity or evolution of injury
- physiotherapy assessment and a report
- range of arm movement with any neurological examination/signs

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For second opinion re management
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review

3. Insert results for required investigations in referral

- x-ray, anteroposterior (AP) & lateral shoulder/elbow
- locking elbow: refer with x-ray, but consider occupation and functional disability
- ultrasound (USS) suspected rotator cuff pathology
- according to clinical suspicion
  - CT scan/MRI (if available)
  - protein electrophoresis
  - immunoglobulins
  - calcium and phosphate
  - rheumatoid serology
- consider: FBC, ESR & CRP if inflammation/ infection suspected

SEND REFERRAL

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

Primary Care Options

- refer to local care pathway **OR**
- analgesia/anti-inflammatories/ NSAIDs as appropriate
- physiotherapy
- activity modification
- advice to avoid dislocation (recurrent)
- shoulder rehabilitation program
- consider corticosteroid injection for:
  - rotator cuff tendinopathy
  - acromio-clavicular joint (ACJ) pain
  - frozen shoulder where pain predominates (early stages)
  - shoulder OA if patient is unwilling/unsuitable for surgical management
  - sub-acromial impingement

Useful Information, where available

- shoulder assessment
- summary of treatment to date
- upper limb questionnaire (where available)

Orthopaedics — Spine/Back Pain

Minimum Referral Criteria

Cat 1	· developing neurological signs and symptoms due to spinal cord compression (sub-acute) · suspected malignancy · suspected infection	Cat 2	· associated with diabetes / immunosuppression · pain with radiation to limbs and neurological deficit · severe disabling pain at rest and with activity despite adequate trial of conservative management o regular simple analgesics o minimum of 6 weeks physiotherapy/exercise program o strengthening exercises and aerobic fitness training	Cat 3	· spinal stenosis with limitation of walking distance · neck pain with arm pain, without neurological signs · mechanical low back pain without leg pain: symptoms persisting ≥ 6 weeks · back pain and sciatica with no neurological signs

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO →

Please insert criteria into referral

1. Pre-Requisite Information

- Ÿ General referral information
- Ÿ duration, history, recurrence of injury and mechanism, severity or evolution of injury
- Ÿ history of malignant disease
- Ÿ treatment to date (including previous spinal surgery)
- Ÿ weight loss, loss of appetite and lethargy
- Ÿ presence and duration of neurological symptoms and signs
- Ÿ functional impairment/time of work
- Ÿ urinary difficulties
- Ÿ physiotherapist report

YES → **Please insert 'Criteria Override' into referral**

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- Ÿ x-ray (AP & lateral spine including standing views)
- Ÿ CT scan/MRI if available
- Ÿ pathology: FBC/E/LFTs/ESR biochemistry/CRP
- calcium and phosphate, electrophoresis, immunoglobin's, PSA, Rheumatoid serology (in specific cases)

SEND REFERRAL

Primary Care Options

refer to local care pathway OR

- Ÿ analgesia/NSAIDs as appropriate
- Ÿ physiotherapy
- Ÿ activity modification (remain comfortably active)
- Ÿ back education group (if available)
- Ÿ complete STarTBack screening tool to identify risk of poor outcome - http://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Back9_item-7.pdf

Useful information, where available

- Ÿ Spinal referral questionnaire (where available): https://www.health.qld.gov.au/rbwh/docs/spinal-questionnaire.pdf

Orthopaedics — Wrist and Hand - Basal thumb arthritis

Minimum Referral Criteria

Cat 1	· N/A	Cat 2	· if associated with inflammatory arthropathy affecting other joints · rapid deterioration in function	Cat 3	· if fails to respond to conservative treatment, such as physiotherapy

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information

YES ←

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

Primary Care Options

- Ÿ refer to local care pathway
  or
- Ÿ anti-inflammatories
- Ÿ splint (hand therapy)
- Ÿ activity modification
- Ÿ consider intra-articular steroid injection

Useful information, where available

- Ÿ treatment to date

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

· x-ray, AP and lateral hand and wrist

SEND REFERRAL

Orthopaedics | Wrist and Hand - Dupuytrens contracture

Minimum Referral Criteria

Cat 1	· Skin breakdown and/or infection secondary to severe contracture	Cat 2	· fixed flexion deformity of 90° at metacarpophalangeal joint (MCPJ) or 60° at Proximal interphalangeal joint (PIPJ) · multiple joints or recurrence after surgery with functional impairment · rapidly progressing disease	Cat 3	· MCP flexion contractures > 30° · PIP flexion contracture >20°. · functional impairment

YES ← **Does the Patient meet the Minimum Referral Criteria?** → **NO**

Please insert criteria into referral

1. Pre-Requisite Information

- Ÿ general referral information
- Ÿ treatment to date (including non-surgical)
- Ÿ range of motion measurements
- Ÿ details of function impairment
- Ÿ anticoagulant therapy
- Ÿ smoking status (It is strongly recommended that people who smoke stop before surgery as it is associated with delayed skin healing. Please consider directing your patient to a smoking cessation program.)

YES → **Please insert 'Criteria Override' into referral**

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- N/A

SEND REFERRAL

Primary Care Options

- Ÿ refer to local care pathway
- Ÿ or
- Ÿ analgesia/NSAIDs (as appropriate)
- Ÿ splint and activity modification
- Ÿ joint range of movement exercises
- Ÿ hand therapy

Useful Information, where available

- Most tertiary Hand Surgery units will soon be offering outpatient based non-surgical treatments for Dupuytren's. Referral to these clinics may be fast tracked.
- PIP joint contractures are more serious than MCP joint contractures

Orthopaedics — Wrist and Hand - Ganglia

Minimum Referral Criteria

Cat 1	· if concerned that lump may be malignant, diagnosis of lump unconfirmed.	Cat 2	• N/A	Cat 3	· refer Cat 3 if diagnosis confirmed as ganglion and: o symptomatic o causing concern o enlarging

Does the Patient meet the Minimum Referral Criteria?

YES ↓

NO ↓

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information

YES ←

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO ↓

Primary Care Options

- refer to local care pathway
  or
- discuss treatment options
- consider aspiration (18g needle) and injection steroid. Do not aspirate volar ganglion
- can repeat if aspiration is ≥ 2 years

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray region involved – bring films to clinic
- ultrasound useful investigation for clarification of presence of cyst

→ **SEND REFERRAL**

Orthopaedics — Wrist and Hand – Painful/stiff wrist

Minimum Referral Criteria

Cat 1	· if history of trauma – refer fracture clinic (depending on local pathways)	Cat 2	· history of inflammatory disease – consider referral to rheumatology · rapid deterioration in function	Cat 3	· refer if x-ray abnormal or if does not respond to adequate conservative treatment, such as physiotherapy.

Does the Patient meet the Minimum Referral Criteria?

YES →

NO →

Please insert criteria into referral

YES →

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO →

1. Pre-Requisite Information

- General referral information
- consider infection, inflammatory and crystal arthropathies as well as arthritis.

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- x-ray (AP and lateral wrist)
- investigations for inflammatory arthropathy
- pathology: FBC, ESR & CRP (if inflammation is suspected)

Primary Care Options

- refer to local care pathway
  or
- anti-inflammatories/ analgesia/ NSAIDs as appropriate
- trial of wrist splint
- physiotherapy (hand therapy)
- activity modification

Useful information, where available

- treatment to date

→ **SEND REFERRAL**

Orthopaedics — Wrist and Hand - Stenosing tenosynovitis

Minimum Referral Criteria

Cat 1	• newly fixed trigger finger	Cat 2	• chronic fixed trigger finger	Cat 3	• suggestive of 1 or more symptoms (tingling/numbness/stiffness/locking/ tenderness/ painful clicking) >6 months • if unresponsive to conservative treatment after one injection and splints • intermittent trigger finger / stenosing tenosynovitis persists

Does the Patient meet the Minimum Referral Criteria?

YES → **Please insert criteria into referral**

NO → **Do you still wish to refer patient and override Minimum Criteria?**

YES → **Please insert 'Criteria Override' into referral**

NO → **Primary Care Options**

- refer to local care pathway
  or
- analgesia/NSAIDs (as appropriate)
- consider steroid injection (as appropriate)
- referral to hand therapy (if available)
- stretching exercises to maintain mobility

1. Pre-Requisite Information

- General referral information
- treatment to date
- describe chronicity
- determine if there is normal passive ROM in the MP, PIP, and DIP joints

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- ultrasound imaging

SEND REFERRAL

Orthopaedics — Wrist and Hand – Upper limb nerve compression

Minimum Referral Criteria

Cat 1	· upper limb radiculopathy in the presence of suspected cervical spine infection or malignancy	Cat 2	· continuous pain and / or muscle weakness in distribution of peripheral upper limb nerve · recurrent symptoms after surgical decompression · rapid progressive deterioration	Cat 3	· intermittent symptoms without weakness or wasting in distribution of peripheral upper limb nerve

Does the Patient meet the Minimum Referral Criteria?

YES

NO

Please insert criteria into referral

1. Pre-Requisite Information

- General referral information
- treatment to date

YES

Please insert 'Criteria Override' into referral

Do you still wish to refer patient and override Minimum Criteria?

NO

2. Reason for Request *indicate on the referral*

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- nerve conduction studies (where available and should not cause significant delay)
- plain radiograph (AP and lateral) of region, if available

Primary Care Options

- Ÿ refer to local care pathway
  or
- Ÿ analgesia/NSAIDs (as appropriate)
- Ÿ night splint (eg carpal tunnel syndrome)
- Ÿ consider steroid injection (eg carpal tunnel syndrome)
- Ÿ hand therapy / physiotherapy - for splinting, joint ROM, neural gliding exercises
- Ÿ advise exercises to maintain mobility

SEND REFERRAL

Draft Urology Clinical Prioritisation Criteria

In-scope for Urology outpatient services

The following conditions are proposed to be considered under the Urology CPC, 2015:

• Recurrent urinary tract infection • Incontinence (Female) • Lower urinary tract symptoms (Female and Male) • Suspected cancer of the prostate (including elevated PSA)	• Haematuria (renal, ureteric, bladder mass/lesion) • Urinary tract calculi • Testicular, Epididymal, Scrotal, Penis/Foreskin abnormalities • Renal mass (tumours / cysts)

In-scope paediatric conditions

The CPC Paediatric Advisory Group (PAG) considered the most common paediatric presentations for each speciality, those conditions where there was the potential to receive unnecessary referrals and those conditions where there may be a waiting list to be reviewed in outpatients.

The CPC PAG did not recommend any paediatric conditions for consideration at this stage; however, paediatric conditions may be added as the CPC is reviewed and updated.

CPC for the general paediatric speciality are also planned to be developed. The PAG will also advise on CPC implementation and how paediatric referrals can be optimally managed.

Out-of-scope for Urology outpatient services

It is proposed that the following are not routinely provided in a public Urology service (exceptions can be made where clinically indicated):

• Circumcision for cosmetic reasons • Aesthetic surgery • Incontinence not causing severe social difficulty • Sexually transmitted – refer Sexual Health Clinic • Genital ulcers and warts – refer Sexual Health Clinic provided verrucous carcinoma is excluded • Ejaculatory disorders	• Vasectomy and vasectomy reversal • Catheter change/maintenance • Proteinuria – refer nephrology • Vaginal prolapse – refer gynaecology • Small epididymal cysts • Simple renal cysts

Emergency referrals

It is proposed that the following conditions should be sent directly to the emergency department:

• Acute/severe renal or ureteric colic • Acute urinary retention • Urinary tract and genital trauma • Urinary tract sepsis or severe infection • Foreign bodies	• Priapism • Acute scrotal pain/ torsion of the testes • Severe genital infection e.g. Fournier's gangrene/epididymo-orchitis • Paraphimosis – unable to reduce

Referral and Outpatient criteria

The information to be included in this section of the CPC is intended to assist:

- GPs and other referring practitioners to identify the point at which a patient may benefit most from referral to medical or surgical specialist services, the information necessary to support the referral and how quickly the patient may be seen.
- Appropriate HHS staff to make transparent and equitable decisions on when referrals should be accepted and the timeframe within which a patient should be seen.

Urology — Haematuria

Minimum Referral Criteria

Cat 1	· Macroscopic haematuria and/or · Imaging showing a bladder mass and/or · Isolated unexplained hydronephrosis on imaging and/or · Persistent microscopic haematuria with - abnormal urine cytology or microscopy and/or - abnormal investigation findings suspicious for malignancy	Cat 2	· Haematuria and proven renal mass on imaging < 4cm	Cat 3	· Persistent microscopic haematuria and · Normal urine cytology and investigation findings not suspicious for malignancy

Does the Patient meet the Minimum Referral Criteria?
Please insert criteria into referral

YES

NO

1. Pre-Requisite Information

- General referral information
- MSU and urine cytology results
- ELFT/FBC
- USS urinary tract or CT IVP results*

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES

NO

2.Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3.Insert results for required investigations in referral

- N/A

Primary Care Options

Ÿ Refer to local care pathway OR
Ÿ MSU microscopy and culture
Ÿ Urine cytology x 3
Ÿ ELFT/FBC
Ÿ USS urinary tracts or CT IVP scan
Ÿ Triple phase CT abdomen/pelvis and CXR if renal mass confirmed on imaging

Useful information, where available

Ÿ Triple phase CT abdomen/pelvis and CXR in patients with a proven renal mass*

SEND REFERRAL

Urology — Incontinence (Female)

Minimum Referral Criteria

Cat 1	· Suspected malignant mass and/or · Bladder outlet obstruction and/or · Haematuria and/or · Elevated post-void residuals and hydronephrosis on USS and / or altered renal function	Cat 2	· Incontinence requiring multiple pad changes per day and · Post-void residual > 100ml and/or · Associated faecal incontinence and/or · Suspected urogenital fistulae	Cat 3	· Incontinence requiring multiple pad changes per day and · Recurrent (>3 per year) or persistent UTI and/or · Persisting bladder or urethral pain and/or · Socially limiting (severe) and/or · Failed Physiotherapy/continence nurse management

Does the Patient meet the Minimum Referral Criteria?
Please insert criteria into referral

YES

1. Pre-Requisite Information

- General referral information
- MSU results
- USS urinary tract results

2. Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- N/A

SEND REFERRAL

NO

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES

NO

Primary Care Options

- Refer to local care pathway OR
- Bladder chart
- MSU
- USS urinary tract and post-void residual
- Physiotherapy and/or continence nurse management e.g. pelvic floor muscle exercises and bladder training
- Consider anticholinergics if low residuals on bladder scan and no suspicion of a sinister cause

Useful information, where available

- Documented episodes of incontinence – bladder chart/diary
- Trial of Void - Time and volume chart
- ELFTs

Urology — Lower Urinary Tract Symptoms (Female)

Minimum Referral Criteria

Cat 1	· Abnormal USS suggestive of urinary tract tumour and/or · Elevated post-void residuals and hydronephrosis on USS and / or altered renal function and/or · Severe irritative symptoms and/or haematuria and/or suspicion of malignancy and/or · Acute retention with IDC	Cat 2	· USS suggestive of bladder outlet obstruction and/or · Bladder stones and/or · Recurrent UTI (>3 per year) and/or · Elevated post void residuals >200ml and/or · Suspected or proven urethral stricture and/or · Acute change in long-term catheter and/or · Persistent or progressive symptoms despite medical management	Cat 3	· N/A

Does the Patient meet the Minimum Referral Criteria?

Please insert criteria into referral

YES

1. Pre-Requisite Information

- General referral information
- MSU
- USS urinary tract results

2. Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- N/A

SEND REFERRAL

NO

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES

NO

Primary Care Options

Ÿ Refer to local care pathway OR
Ÿ MSU
Ÿ Consider USS *

Useful information, where available

Ÿ N/A

Urology — Lower Urinary Tract Symptoms (Male)

Minimum Referral Criteria

Cat 1	· Abnormal USS suggestive of urinary tract tumour and/or · Acute retention with IDC and/or · New elevated Prostate Specific Antigen (PSA)>10ng/ml and/or · Elevated post-void residuals and hydronephrosis on USS and/or altered renal function and/or · Haematuria and/or irritative symptoms	Cat 2	· USS suggestive of bladder outlet obstruction and/or · Bladder stones and/or · Recurrent UTI (>1 per year) and/or · Incontinence and/or · Elevated PSA <10ng/ml and/or · Elevated post-void residuals >200ml and/or · Suspected or proven urethral stricture and/or · Suspected or symptomatic benign prostatic hypertrophy (BPH) or prostatomegaly and/or · Acute change in long-term catheter and/or · Persistent or progressive symptoms despite medical management	Cat 3	· N/A

Does the Patient meet the Minimum Referral Criteria?
Please insert criteria into referral

YES

1. Pre-Requisite Information

- General referral information
- ELFTs
- MSU results
- USS urinary tract results*

2. Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- N/A

SEND REFERRAL

NO

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES

NO

Primary Care Options

- Ÿ refer to local care pathway OR
- Ÿ Medical Management
- Ÿ Bladder chart and the International Prostate Symptom Score sheet
- Ÿ Physiotherapy and/or continence nurse management e.g. pelvic floor muscle exercises and bladder training
- Ÿ MSU (micro and culture)
- Ÿ USS urinary tract*
- Ÿ PSA if >40 years old
- Ÿ ELFTs
- Ÿ Trial of alpha blockers if appropriate

Useful information, where available

- Ÿ PSA history
- Ÿ Family history of prostate cancer
- Ÿ Bladder chart and the International Prostate Symptom Score sheet

Urology — Prostate - suspected cancer (including elevated PSA)

Minimum Referral Criteria

Cat 1	· PSA >10ng/ml and/or · Radiological imaging indicative of ureteric obstruction and/or · Palpable or suspicious nodule	Cat 2	· Increasing/elevated age-related PSA on 2 or more interval specimens and/or · Abnormal digital rectal examination	Cat 3	· N/A

Does the Patient meet the Minimum Referral Criteria?

Please insert criteria into referral

YES ↓

NO ↓

1. Pre-Requisite Information

- General referral information
- PSA/ELFT/FBC
- MSU results
- USS urinary tract results*

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES ← (from above)

NO ↓

2. Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral

- N/A

Primary Care Options

- Ÿ Refer to local care pathway OR
- Ÿ Repeat PSA in 4-6 weeks if elevated
- Ÿ ELFTs/FBC
- Ÿ MSU
- Ÿ Bladder chart and the International Prostate Symptom Score
- Ÿ USS urinary tract*

Useful information, where available

- Ÿ Bladder chart and the International Prostate Symptom Score
- Ÿ PSA history
- Ÿ Family history of prostate cancer

→ **SEND REFERRAL**

Urology — Renal Mass (Tumours / Cysts)

Minimum Referral Criteria

Cat 1	· Imaging showing: - solid renal mass > 4 cm and/or - mucosal/collecting system lesion and/or - complex cystic lesion > 4cm in size	Cat 2	· Imaging showing: - solid or complex cystic renal mass < 4 cm and/or - Angiomyolipoma > 4cm and/or - Angiomyolipoma < 4cm in a woman of child bearing age and/or - PUJ obstruction and/or - large symptomatic simple renal cyst	Cat 3	· Imaging showing Angiomyolipoma < 4cm

Does the Patient meet the Minimum Referral Criteria?

YES

Please insert criteria into referral

NO

1. Pre-Requisite Information

- General referral information
- USS urinary tract or CT IVP results

YES

Do you still wish to refer patient despite not meeting Minimum Criteria?

NO

2.Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3.Insert results for required investigations in referral

- N/A

SEND REFERRAL

Primary Care Options

Ÿ Refer to local care pathway OR
Ÿ USS and/or CT IVP
Ÿ Consider Tc99m-MAG3 renography if PUJ obstruction suspected

Useful information, where available

Ÿ Tc99m-MAG3 renography

Urology — Testicular/Epididymal/Scrotal/Penis/Foreskin abnormalities

Minimum Referral Criteria

Cat 1	· Scrotal pain or swelling with - painful swollen testis/epididymis and/or - painless, solid, testicular mass or swelling suspicious of testicular cancer · Suspected penile cancer or tumour	Cat 2	· Scrotal pain or swelling with - hydrocele/varicocele and/or - painful or large epididymal cyst · Intermittent testicular pain suggestive of intermittent testicular torsion and/or · Haematospermia and/or · Foreskin phimosis and/or · Penile discharge or lesions or balanitis (excluding genital warts)	Cat 3	· Erectile dysfunction not responding to maximal primary care management and/or · Peyronie's disease causing functional impairment or pain and/or · Chronic testicular pain

Does the Patient meet the Minimum Referral Criteria?
Please insert criteria into referral

YES

NO

1. Pre-Requisite Information

- General referral information
- MSU results
- USS scrotum/testes results

YES

Do you still wish to refer patient despite not meeting Minimum Criteria?

NO

2. Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request

3. Insert results for required investigations in referral

- N/A

SEND REFERRAL

Primary Care Options

Ÿ refer to local care pathway OR
Ÿ Trial of steroid cream for phimosis
Ÿ MSU
Ÿ Urine polymerase chain reaction (PCR) and/or swabs for chlamydia and gonorrhoea for suspected epididymo-orchitis
Ÿ Urine cytology if indicated
Ÿ USS scrotum/testes
Ÿ If suspected or confirmed STI refer sexual health clinic
Ÿ For erectile dysfunction
  – Lifestyle changes – PDE5 inhibitors
  – HRT – Psychology
  – External devices – Physiotherapy for pelvic floor exercises
  – Comorbidity management (e.g. diabetes, heart disease)

Useful information, where available

Ÿ Urine PCR and/or swabs results if indicated
Ÿ Urine cytology results if indicated

Urology — Urinary tract calculi

Minimum Referral Criteria

Cat 1	· Proven calculi in ureter with - decreased renal function and/or increasing pain and/or evidence of UTI and/or - evidence of high grade obstruction on imaging and/or - high risk patients e.g. patients with single kidney/renal transplant	Cat 2	· Proven calculi in kidney with - resolved symptoms and/or - recurrent symptoms · All staghorn stones	Cat 3	· N/A

Does the Patient meet the Minimum Referral Criteria?

Please insert criteria into referral

YES

NO

1. Pre-Requisite Information

- General referral information
- MSU results
- ELFTs/FBC
- CT KUB (non-contrast) results* (preferred) or USS urinary tract results

YES

Do you still wish to refer patient despite not meeting Minimum Criteria?

NO

2.Type of Request indicate on the referral

- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3.Insert results for required investigations in referral

- N/A

SEND REFERRAL

Primary Care Options

Ÿ Refer to local care pathway OR
Ÿ Analgesia –
  – NSAIDs
  – Consider an alpha blocker e.g.Tamsulosin 400 micrograms
Ÿ MSU
Ÿ ELFTs/FBC, serum calcium and urate
Ÿ CT KUB (non-contrast) and Xray KUB
Ÿ Stone prevention advice

Useful information, where available

Ÿ If patient has passed previous stone and this has been examined, include details of calculi
Ÿ Parathyroid hormone, ionised calcium
Ÿ Xray/KUB results
Ÿ Serum calcium and urate results

Urology — Urinary Tract Infection (UTI) - Recurrent

Minimum Referral Criteria

Cat 1	· Recurrent (women >3 per year, men >1 per year) or persistent UTI with: - abnormal urinary tract ultrasound e.g. hydronephrosis, stones, scarring, soft tissue lesion · Recent history (3 months) of admission for severe urinary tract sepsis	Cat 2	· Recurrent (women >3 per year, men >1 per year) or persistent UTI with: - increased residuals >100ml and/or - upper urinary tract infections	Cat 3	· Recurrent UTI (women >3 per year, men >1 per year)

Does the Patient meet the Minimum Referral Criteria?
Please insert criteria into referral

YES

1. Pre-Requisite Information
- General referral information
- MSU results
- USS urinary tract results

2. Type of Request indicate on the referral
- To establish a diagnosis
- For treatment or intervention
- For patient/family request
- For a test/investigation the GP can't order, or the patient can't afford or access
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement requires specialist review
- For second opinion re management

3. Insert results for required investigations in referral
- N/A

SEND REFERRAL

NO

Do you still wish to refer patient despite not meeting Minimum Criteria?

YES

NO

Primary Care Options
- Refer to local care pathway OR
- MSU
- STI screen if appropriate
- Antibiotics
- Urinary tract ultrasound (USS) and Post void residual
- Consider urinary alkalising agent ural / cranberry juice
- Consider alpha blockers if high residual volume with benign prostatism in men

Useful information, where available
- ELFTs
- STI screen results