Clinical Prioritisation Criteria (CPC)

CPC End-user Testing

Sunshine Coast

November 2015
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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.


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

Select "condition"

CPC minimum referral criteria met?

Yes

Complete referral including:
• Note referral is "consistent with CPC"
• Pre-requisite information
• Type of referral
• Results of investigations

Send Referral

No

Referral required despite not meeting criteria?

No

Continue with Primary Care

Yes

Complete referral including:
• Note "CPC clinical override"
• Pre-requisite information
• Type of referral
• Results of investigations
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:

<table>
<thead>
<tr>
<th>For referring practitioners:</th>
<th><a href="https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_GPs">https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_GPs</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>For Hospital &amp; Health Service staff:</td>
<td><a href="https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_HHS">https://www.surveymonkey.com/r/CPC_End_User_Testing_Feedback_Survey_SC_HHS</a></td>
</tr>
</tbody>
</table>

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/trialed 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

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• high-grade squamous intraepithelial lesion (HSIL) on pap smear&lt;br&gt; • any glandular cervical lesion suspected on pap smear&lt;br&gt; • SCC cervix</td>
<td>• low-grade squamous intraepithelial lesion (LSIL) x 2 on pap smears 12 months apart&lt;br&gt; • LSIL &gt;30 years of age (No pap smear in past 2 – 3 years)</td>
<td>• N/A</td>
</tr>
</tbody>
</table>

### Does the Patient meet the Minimum Referral Criteria?

**YES**

Please insert criteria into referral

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**
   - 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

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

**NO**

**YES**

Please insert 'Criteria Override' into referral

### Primary Care Options

Refer to local care pathway OR
- Unsatisfactory smear – repeat in 6-12 weeks after correction of problem
- Consider using Oestrogen cream +/- liquid cytology in post-menopausal patients
- 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

- Send Referral
## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>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</td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

**Please insert criteria into referral**

**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
  - Address excessive exercise or dieting
  - Address obesity if relevant
  - Address any significant stress or anxiety
  - Review medications if relevant (e.g. antipsychotics, metoclopramide)

**Useful information**
- Exclude pregnancy and prolactinoma
# Cervical polyp

## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• cervical polyp with abnormal pap smear</td>
<td>• cervical polyps in post-menopausal women with normal pap smear</td>
<td>• cervical polyps in pre-menopausal women</td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

- **YES**
- **NO**

### Pre-Requisite Information

- general referral information
- findings of speculum examination

### Reason for Request

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

### Insert results for required investigations in referral

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

---

### Primary Care Options

- Refer to local care pathway OR
  - Small endocervical polyps (<2cm) in premenopausal women with a normal pap smear can be avulsed and sent for histology
  - Cervical polyps in post-menopausal women have a higher risk of malignancy

---

*Please insert criteria into referral*

*Please insert 'Criteria Override' into referral*

*Please insert 'YES' or 'NO' for referral decision*

*Send referral*
### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>- likelihood of inpatient admission&lt;br&gt;- multiple Emergency Department presentations&lt;br&gt;- endometriomas on USS&lt;br&gt;- associated bowel or bladder disturbance</td>
</tr>
<tr>
<td>3</td>
<td>- chronic pain&lt;br&gt;- those not responding to suppression of menstrual cycle</td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

**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

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*

**Primary Care Options**
- refer to local care pathway
- OR
  - suppression of menstrual cycle with oral contraceptive pill / Implanon / Depo-Provera / Mirena®. 6 month trial appropriate prior to referral

**Useful information**
- NICE in development [GID-CGWAVE0737] Anticipated publication date: May 2017

---

*SEND REFERRAL*
Gynaecology

Fibroids

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 as ureteric impingement)
- HMB with anaemia
- abdominal discomfort

**Cat 3**
- Heavy Menstrual Bleeding

---

**Yes**

Does the Patient meet the Minimum Referral Criteria?

Please insert criteria into referral

1. **Pre-Requisite Information**
   - General referral information
   - symptoms
   - heavy menstrual bleeding
   - dragging sensation
   - urinary frequency

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

---

**Yes**

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

Please insert ‘Criteria Override’ into referral

**No**

---

**Primary Care Options**
refer to local care pathway

OR

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

ü

-16-
Heavy Menstrual Bleeding (HMB)

**Minimum Referral Criteria**

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • suspicion of malignancy  
  • heavy menstrual bleeding (HMB) requiring blood transfusion  
  • heavy menstrual bleeding (HMB) with anaemia (Hb<85) | • heavy menstrual bleeding (HMB) with anaemia (Hb>85) | • 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

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

**Primary Care Options**

refer to local care pathway  
OR
Consider increased risk of hyperplasia or malignancy if
- endometrial thickness greater than 12mm  
  (transvaginal ultrasound ideally day 4-7)  
  (CancerAustralia 2011)  
- weight >90kg  
- polycystic ovary syndrome (PCOS) / diabetes / unopposed oestrogen  
- age >45yrs  
- intermenstrual or post-coital bleeding  

**Treatment:**
- oral contraceptive pill (OCPs)  
- non-steroidal anti-inflammatory drugs (NSAIDS)  
- Tranexamic acid  
- Mirena® Intrauterine System (IUS)  
- oral progestogens (NHC Guidelines)

**SEND REFERRAL**
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?

Please insert criteria into referral

1. Pre-Requisite Information
   - General referral information
   - History of
     - previous pregnancies
     - sexually transmitted diseases (STDs) and pelvic inflammatory disease (PID)
     - surgery
   - Endometriosis
   - Other medical conditions
   - Include the following information about partner
     - Age and health
     - 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
   - 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.
   - History of marijuana use (including partner) – make reference if appropriate
   - IVF not available in public hospitals
   - Testosterone and free androgen index test for those likely to have Polycystic Ovarian Syndrome (PCOS)

SEND REFERRAL

Primary Care Options
- refer to local care pathway
- Smoking cessation
- Optimise health
- Achieve optimal weight BMI 20 – 30
- Folic Acid 0.5mg/day

Useful information
- 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.
- History of marijuana use (including partner) – make reference if appropriate
- IVF not available in public hospitals
- Testosterone and free androgen index test for those likely to have Polycystic Ovarian Syndrome (PCOS)
# Intermenstrual bleeding

## Minimum Referral Criteria

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

### Does the Patient meet the Minimum Referral Criteria?

**YES**

#### Pre-Requisite Information
- general referral information
- findings of speculum examination

#### Reason for Request
- 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

#### 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)

### 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

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

SEND REFERRAL
## Gynaecology

### Ovarian cyst / pelvic mass

#### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • 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. | • persistent cyst >5cm on 2 pelvic ultrasound scans 6 weeks apart.  
• persistent pain  
• complex cyst (haemorrhagic, endometriotic or dermoid) | • hydrosalpinx |

#### Does the Patient meet the Minimum Referral Criteria?

- **YES**

- **NO**

---

#### Pre-Requisite Information

- General referral information  
- History including pain and other symptoms

---

#### 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

---

#### Insert results for required investigations in referral

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

---

#### Primary Care Options

Refer to local care pathway OR
- If cyst simple or haemorrhagic corpus luteal cyst and <5 cm repeat scan in 6 – 12 weeks
- If recurrent cysts, consider combined oral contraceptive pill (COCP) or Implanon.
- If suspected torsion, refer Emergency Department.

---

#### Useful information

- Ask for family history of breast and ovarian cancer

---

**SEND REFERRAL**
# Pelvic pain

## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| N/A   | • likelihood of inpatient admission  
• multiple Emergency Department presentations  
  - abnormal changes on ultrasound  
  - presence of endometriomas / fixed retroverted uterus | • pelvic pain not responding to primary care |

## Does the Patient meet the Minimum Referral Criteria?**

**Please insert criteria into referral**

### 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
- 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)

## Primary Care Options
- refer to local care pathway OR
- treat infection if present
- simple analgesia
- suppress menstrual cycle with oral contraceptive pill / Implanon / Depo-Provera / Mirena*
- treat dysmenorrhoea with non-steroidal anti-inflammatory drugs (NSAID) or combined oral contraceptive pill (COCP)

## Useful information
- associated cyclical bladder, bowel symptoms

---

**YES** **NO**

Please insert ‘Criteria Override’ into referral

**YES** **NO**

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

Please insert criteria into referral

**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)

### Primary Care Options

refer to local care pathway

### Useful information

Reference Material
Investigation of intermenstrual and postcoital bleeding (RANZCOG 2015)
Post-menopausal bleeding
(Vaginal bleeding more than 12 months following last menstrual period)

Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • endometrial thickness >4mm  
• cervical polyps  
• suspicion of malignancy  
• focal endometrial lesion | • endometrial thickness ≤4mm | • N/A |

Does the Patient meet the Minimum Referral Criteria?

YES

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

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

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
## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ulcerated uterine prolapse</td>
<td>severe prolapse with obstructive symptoms</td>
<td>prolapse other than category 1 or category 2</td>
</tr>
<tr>
<td>urinary obstruction</td>
<td>difficulty voiding</td>
<td>urinary incontinence</td>
</tr>
<tr>
<td></td>
<td>recurrent urinary tract infections (UTI's)</td>
<td>obstructive defecation</td>
</tr>
<tr>
<td></td>
<td>o +/- significant residuals on bladder scanning</td>
<td></td>
</tr>
</tbody>
</table>

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

### Reason for Request
- 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

### 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

### Primary Care Options
- refer to local care pathway
- 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

---

**SEND REFERRAL**
Draft Orthopaedic Clinical Prioritisation Criteria

In-scope for Orthopaedic outpatient services

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

<table>
<thead>
<tr>
<th>Upper limb</th>
<th>Spine/Back Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>shoulder/elbow</td>
<td>arthritis</td>
</tr>
<tr>
<td>- osteoarthritis</td>
<td>- disc related</td>
</tr>
<tr>
<td>- pain/stiffness including frozen shoulder</td>
<td>- neoplastic and infection</td>
</tr>
<tr>
<td>- rotator cuff tears/tendinopathy</td>
<td></td>
</tr>
<tr>
<td>- AC joint problems</td>
<td></td>
</tr>
<tr>
<td>- shoulder/elbow instability</td>
<td></td>
</tr>
<tr>
<td>- recurrent dislocation of shoulder</td>
<td></td>
</tr>
<tr>
<td>- wrist and hand</td>
<td></td>
</tr>
<tr>
<td>- stenosing tenosynovitis</td>
<td></td>
</tr>
<tr>
<td>- Dupuytrens contracture</td>
<td></td>
</tr>
<tr>
<td>- basal thumb arthritis</td>
<td></td>
</tr>
<tr>
<td>- ganglia</td>
<td></td>
</tr>
<tr>
<td>- painful/stiff wrist</td>
<td></td>
</tr>
<tr>
<td>- upper limb peripheral nerve compression</td>
<td></td>
</tr>
<tr>
<td>- pain and instability in hind foot</td>
<td></td>
</tr>
</tbody>
</table>

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

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

### Does the Patient meet the Minimum Referral Criteria?

**YES**

**NO**

---

#### 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

#### Reason for Request

- 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

#### Insert results for required investigations in referral

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

---

### Primary Care Options

- Refer to local care pathway
- 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)

---

**SEND REFERRAL**
<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• skin ulceration secondary to deformity or pressure (High Risk Foot Clinic - where available)</td>
<td>• presence of avascular necrosis</td>
<td>• functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss</td>
</tr>
</tbody>
</table>

**Minimum Referral Criteria**

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

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**

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

**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 – Heel Pain

<table>
<thead>
<tr>
<th>Minimum Referral Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cat 1</strong></td>
</tr>
<tr>
<td><strong>Cat 2</strong></td>
</tr>
<tr>
<td><strong>Cat 3</strong></td>
</tr>
</tbody>
</table>

---

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

Please insert criteria into referral

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
   - Nerve irritation signs (Tinel’s sign or hyperaesthesia)
   - 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**

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

**Useful Information, where available**

- Treatment carried out to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports (if available)
# Orthopaedics - Heel and Foot - Pain / deformity in forefoot and hind foot

## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• if associated with trauma, infection, suspected fracture or ulceration refer to fracture clinic</td>
<td>• if associated with diabetic neuropathy threatened ulceration</td>
<td>• functional impairment a pain persists despite active conservative treatment, such as physiotherapy or managed weight loss</td>
</tr>
</tbody>
</table>

## Does the Patient meet the Minimum Referral Criteria?

**Please insert criteria into referral**

### 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
- 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

## Primary Care Options
- Refer to local care pathway or analgesia/NSAIDs as appropriate
- Check tibialis posterior
- Modification footwear/arch supports (where available)
- Physiotherapy/podiatry (where available)
- Orthoses (where available)
- Weight loss management
- Consider ultrasound-guided steroid injection for Morton’s neuroma/intermetatarsal bursa (as appropriate)

## Useful Information, where available
- Treatment carried out to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports (if available)

**SEND REFERRAL**
# Orthopaedics

## Fractures – Hand Fractures

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>undisplaced fractures</td>
<td>fracture delayed union or non-union</td>
<td>mal-union – normal function</td>
</tr>
<tr>
<td>fractures that have been reduced satisfactorily</td>
<td>mal-union affecting function</td>
<td></td>
</tr>
</tbody>
</table>

### Does the Patient meet the Minimum Referral Criteria?

**YES**

**NO**

**Please insert criteria into referral**

**1. Pre-Requisite Information**
- General referral information
- Previous orthopaedic conditions and operations
- Date, time, mechanism, severity or evolution of injury
- Other joint involvement
- 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)

**Primary Care Options**
- Refer to local care pathway
- Assess and document neurovascular status
- Check x-ray post manipulation (if applicable)
- Immobiliser or plaster cast (as appropriate)
- Acute fractures will be assessed by fracture clinic within 2 weeks

**Useful information, where available**
- Do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar on-call.
- Please refer early as treatment may change with a delayed referral
- Summarise treatment to date

**SEND REFERRAL**
Orthopaedics  Fractures – Lower limb fractures

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • undisplaced fractures  
• fractures that have been reduced satisfactorily | • fractures delayed or non-union  
• mal-union affecting function | • mal-union not affecting function |

**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)

**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
- Assess and document neurovascular status
- Check x-ray post manipulation (if applicable)
- Immobiliser or plaster cast (as appropriate)
- Acute fractures will be assessed by fracture clinic within 2 weeks

Useful information, where available
- Do not delay referral for all open, unstable fractures — refer to emergency or contact the orthopaedic registrar

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

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>osteoporotic / pathological fractures suspected malignancy or chronic infection&lt;br&gt;• acute infection or abscess to Emergency Department</td>
<td>osteoporotic / insufficiency fracture with ongoing pain</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Does the Patient meet the Minimum Referral Criteria?

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

Primary Care Options
- refer to local care pathway
- 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**

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • undisplaced fractures  
• fractures that have been reduced satisfactorily | • fractures delayed or non-union  
• mal-union affecting function | • mal-union not affecting function |

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

Please insert criteria into referral

**NO**

**Please insert ‘Criteria Override’ into referral**

**Pre-Requisite Information**

1. General referral information  
2. Previous orthopaedic conditions and operations  
3. Date, time, mechanism, severity or evolution of injury  
4. Treatment to date (cast, splint etc)  
5. Other joint involvement

**Reason for Request**

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

**Insert results for required investigations in referral**

1. X-ray results (scaphoid views only if out of plaster)  
2. Instruct patient to bring imaging films/results to clinic appointment

**Primary Care Options**

- Refer to local care pathway  
- Assess and document neurovascular status  
- Check x-ray post manipulation (if applicable)  
- Immobilise fracture limb in a sling, shoulder immobiliser or plaster cast (as appropriate)  
- Acute fractures will be assessed by fracture clinic within 2 weeks

**Useful information, where available**

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

**SEND REFERRAL**
## Orthopaedics

### Hip and Knee – Acute Knee Injury

#### Minimum Referral Criteria

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

---

### Does the Patient meet the Minimum Referral Criteria?

**YES**

**NO**

---

#### Please insert criteria into referral

<table>
<thead>
<tr>
<th>1. Pre-Requisite Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• General referral information</td>
</tr>
<tr>
<td>• date, history, recurrence of injury and mechanism, severity or evolution of injury</td>
</tr>
<tr>
<td>• pain and other symptoms including haemarthrosis/effusion, locking, instability</td>
</tr>
<tr>
<td>• results of clinical ligament and meniscus tests if completed</td>
</tr>
<tr>
<td>• true locking (vs intermittent stiffness)</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>2. Reason for Request indicate on the referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To establish a diagnosis</td>
</tr>
<tr>
<td>• For treatment or intervention</td>
</tr>
<tr>
<td>• For patient/family request</td>
</tr>
<tr>
<td>• For a test/investigation the GP can’t order, or the patient can’t afford or access</td>
</tr>
<tr>
<td>• For other reason (e.g. rapidly accelerating disease progression)</td>
</tr>
<tr>
<td>• Clinical judgement requires specialist review</td>
</tr>
<tr>
<td>• For second opinion re management</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>3. Insert results for required investigations in referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>• plain x-ray of knee weight bearing AP, lateral and skyline</td>
</tr>
<tr>
<td>• MRI if possible, for acute knee injury (if available)</td>
</tr>
</tbody>
</table>

---

### Primary Care Options

- refer to local care pathway
- 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

---

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

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • evidence of acute inflammation for example:  
  ○ haemarthrosis  
  ○ tense effusion  
| • symptoms rapidly deteriorating and causing severe disability  
  • pain in previously well-functioning arthroplasty  
| • Some functional impairment and ongoing pain persists despite active conservative treatment, such as physiotherapy or managed weight loss |

**Please insert criteria into referral**

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

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

**YES**

**NO**

### 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

### 2. Reason for Request

- 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

**Primary Care Options**

- refer to local care pathway
- 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

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • past history or suspicion of neoplasm +/- lesion on x-ray. | • 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 | • functional impairment and/or pain persists despite active conservative treatment, such as physiotherapy or managed weight loss |
| • radiological evidence of avascular necrosis of hip in a patient <60 years | | |

**Does the Patient meet the Minimum Referral Criteria?**

**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

**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

**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

### 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  

### 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
- Instability
- Recurrent dislocation of shoulder
- Sub-acromial impingement

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Suspicion of malignancy</td>
<td>- Patient is &lt;25 y/o with first-time shoulder dislocation</td>
<td>- If functional impairment and / or pain persists despite active conservative treatment such as physiotherapy or managed weight loss</td>
</tr>
<tr>
<td>- Evidence of acute inflammation, for example:</td>
<td>- Recurrent dislocated shoulder/shoulder instability</td>
<td>- Acromio-clavicular (ACJ) joint conditions</td>
</tr>
<tr>
<td>- Haemarthrosis</td>
<td>- Instability associated with structural pathology (e.g. Superior Labral Antero-Posterior (SLAP) lesion, large Bankart lesion) in a younger patient (&lt;40y/o)</td>
<td>- Chronic weakness and degenerative cuff</td>
</tr>
<tr>
<td>- Tense effusion</td>
<td>- History of trauma suggests acute event / tear (rather than degenerative) rotator cuff tear,</td>
<td>- Cuff tendinopathy</td>
</tr>
<tr>
<td></td>
<td>- Shoulder adhesive capsulitis (frozen shoulder)</td>
<td>- Sub-acromial impingement</td>
</tr>
</tbody>
</table>

### Does the Patient meet the Minimum Referral Criteria?

- **Yes**

  **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**
     - To establish a diagnosis
     - For treatment or intervention
     - For patient/family request
     - For second opinion request
     - 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 (US) 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

- **No**

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

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

  - **Yes**
  - **No**

### Primary Care Options

- Refer to local care pathway OR
- Analgesia/anti-inflammatory/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)

**SEND REFERRAL**
## Orthopaedics

### Spine/Back Pain

#### Minimum Referral Criteria

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

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

**Please insert criteria into referral**

1. **Pre-Requisite Information**

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

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

**Primary Care Options**

- refer to local care pathway OR
- analgesia/NSAIDs as appropriate
- physiotherapy
- activity modification (remain comfortably active)
- back education group (if available)
- 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](http://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Back9_item-7.pdf)

**Useful information, where available**


**Send Referral**

**YES**

**Please insert ‘Criteria Override’ into referral**

**NO**

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

**YES**

**NO**

-39-
### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• N/A</td>
<td>• if associated with inflammatory arthropathy affecting other joints • rapid deterioration in function</td>
<td>• if fails to respond to conservative treatment, such as physiotherapy</td>
</tr>
</tbody>
</table>

#### Does the Patient meet the Minimum Referral Criteria?

**YES**

#### Please insert criteria into referral

**1. Pre-Requisite Information**
- General referral information

**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

**YES**

#### Please insert ‘Criteria Override’ into referral

**NO**

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

**YES**

**NO**

---

**Primary Care Options**
- refer to local care pathway
- anti-inflammatories
- splint (hand therapy)
- activity modification
- consider intra-articular steroid injection

**Useful Information, where available**
- treatment to date

**SEND REFERRAL**
<table>
<thead>
<tr>
<th>Minimum Referral Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cat 1</strong></td>
</tr>
<tr>
<td><strong>Cat 2</strong></td>
</tr>
<tr>
<td><strong>Cat 3</strong></td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

1. **Pre-Requisite Information**
   - general referral information
   - treatment to date (including non-surgical)
   - range of motion measurements
   - details of function impairment
   - anticoagulant therapy
   - 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.)

2. **Reason for Request**
   - 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**
**Orthopaedics**  
**Wrist and Hand - Ganglia**

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • if concerned that lump may be malignant, diagnosis of lump unconfirmed. | • N/A | • 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

**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

#### Primary Care Options

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

---

**SEND REFERRAL**
Orthopaedics

Wrist and Hand – Painful/stiff wrist

**Minimum Referral Criteria**

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • if history of trauma – refer fracture clinic (depending on local pathways) | • history of inflammatory disease – consider referral to rheumatology  
 • rapid deterioration in function | • 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**

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)

**Send Referral**
<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>newly fixed trigger finger</td>
<td>chronic fixed trigger finger</td>
<td>suggestive of 1 or more symptoms (tingling/numbness/stiffness/locking/tenderness/painful clicking) &gt;6 months</td>
</tr>
<tr>
<td>if unresponsive to conservative treatment after one injection and splints</td>
<td>intermittent trigger finger / stenosing tenosynovitis persists</td>
<td></td>
</tr>
</tbody>
</table>

### Minimum Referral Criteria

**Does the Patient meet the Minimum Referral Criteria?**

**Please insert criteria into referral**

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**
   - 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

### Primary Care Options

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

**SEND REFERRAL**
# Orthopaedics

## Wrist and Hand – Upper limb nerve compression

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>upper limb radiculopathy in the presence of suspected cervical spine infection or malignancy</td>
</tr>
<tr>
<td>2</td>
<td>continuous pain and / or muscle weakness in distribution of peripheral upper limb nerve, recurrent symptoms after surgical decompression, rapid progressive deterioration</td>
</tr>
<tr>
<td>3</td>
<td>intermittent symptoms without weakness or wasting in distribution of peripheral upper limb nerve</td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

**YES**

**Please insert criteria into referral**

1. **Pre-Requisite Information**
   - General referral information
   - 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**
   - Nerve conduction studies (where available and should not cause significant delay)
   - Plain radiograph (AP and lateral) of region, if available

**Send Referral**

**NO**

**Please insert ‘Criteria Override’ into referral**

**Primary Care Options**

- Refer to local care pathway
- Analgesia/NSAIDs (as appropriate)
- Night splint (eg carpal tunnel syndrome)
- Consider steroid injection (eg carpal tunnel syndrome)
- Hand therapy / physiotherapy - for splinting, joint ROM, neural gliding exercises
- Advise exercises to maintain mobility
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 | Haematuria (renal, ureteric, bladder mass/lesion) |
| Incontinence (Female)            | Urinary tract calculi                           |
| Lower urinary tract symptoms (Female and Male) | Testicular, Epididymal, Scrotal, Penis/Foreskin abnormalities |
| Suspected cancer of the prostate (including elevated PSA) | 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):

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

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Macroscopic haematuria and/or</td>
<td>- Haematuria and proven renal mass on imaging &lt; 4cm</td>
<td>- Persistent microscopic haematuria and/or</td>
</tr>
<tr>
<td>- Imaging showing a bladder mass and/or</td>
<td></td>
<td>- Normal urine cytology and investigation findings not suspicious for malignancy</td>
</tr>
<tr>
<td>- Isolated unexplained hydronephrosis on imaging and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Persistent microscopic haematuria with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- abnormal urine cytology or microscopy and/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- abnormal investigation findings suspicious for malignancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Does the Patient meet the Minimum Referral Criteria?**

Please insert criteria into referral

1. **Pre-Requisite Information**
   - General referral information
   - MSU and urine cytology results
   - ELFT/FBC
   - USS urinary tract or CT IVP 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

---

---

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

Useful information, where available
- Triple phase CT abdomen/pelvis and CXR in patients with a proven renal mass*

---

SEND REFERRAL
## Incontinence (Female)

### Minimum Referral Criteria

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

### Does the Patient meet the Minimum Referral Criteria?

**Please insert criteria into referral**

**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

### SEND REFERRAL

---
Lower Urinary Tract Symptoms (Female)

**Minimum Referral Criteria**

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
</table>
| • 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 | • 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 | • N/A |

**Does the Patient meet the Minimum Referral Criteria?**

**Please insert criteria into referral**

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**
# Urology

## Lower Urinary Tract Symptoms (Male)

### Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>· Abnormal USS suggestive of urinary tract tumour and/or Acute retention with IDC and/or New elevated Prostate Specific Antigen (PSA)&gt;10ng/ml and/or Elevated post-void residuals and hydronephrosis on USS and/or altered renal function and/or Haematuria and/or irritative symptoms</td>
<td>· USS suggestive of bladder outlet obstruction and/or Bladder stones and/or Recurrent UTI (&gt;1 per year) and/or Incontinence and/or Elevated PSA &lt;10ng/ml and/or Elevated post-void residuals &gt;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</td>
<td>· N/A</td>
</tr>
</tbody>
</table>

### Does the Patient meet the Minimum Referral Criteria?

**Yes**

1. **Pre-Requisite Information**
   - General referral information
   - ELFTs
   - MSU 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**

---

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

**Useful information, where available**
- PSA history
- Family history of prostate cancer
- Bladder chart and the International Prostate Symptom Score sheet
# Prostate - suspected cancer (including elevated PSA)

## Minimum Referral Criteria

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

### Does the Patient meet the Minimum Referral Criteria?

- **YES**
  - Please insert criteria into referral

- **NO**
  - Do you still wish to refer patient despite not meeting Minimum Criteria?
    - **YES**
    - **NO**

### 1. Pre-Requisite Information

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

### 2. Type of Request

- 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

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

### Useful information, where available

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

**SEND REFERRAL**
### Minimum Referral Criteria

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

---

### Does the Patient meet the Minimum Referral Criteria?

**Yes**

1. **Pre-Requisite Information**
   - General referral information
   - USS urinary tract or CT IVP results

2. **Type of Request**
   - 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**

---

**Yes**

**No**

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

**Useful information, where available**
- Tc99m-MAG3 renography

---

**NO**

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

**Yes**
## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1</td>
<td>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</td>
</tr>
<tr>
<td>Cat 2</td>
<td>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)</td>
</tr>
<tr>
<td>Cat 3</td>
<td>Erectile dysfunction not responding to maximal primary care management and/or - Peyronie’s disease causing functional impairment or pain and/or - Chronic testicular pain</td>
</tr>
</tbody>
</table>

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

1. **Pre-Requisite Information**
   - General referral information
   - MSU results
   - USS scrotum/testes results

2. **Type of Request**
   - To establish a diagnosis
   - For treatment or intervention
   - For patient/family request

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

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**Primary Care Options**
- Refer to local care pathway OR
- Trial of steroid cream for phimosis
- MSU
- Urine polymerase chain reaction (PCR) and/or swabs for chlamydia and gonorrhoea for suspected epididymo-orchitis
- Urine cytology if indicated
- USS scrotum/testes
- If suspected or confirmed STI refer sexual health clinic
- 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**
- Urine PCR and/or swabs results if indicated
- Urine cytology results if indicated

---

**SEND REFERRAL**

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**NO**

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

**YES**
# Urinary tract calculi

## Minimum Referral Criteria

<table>
<thead>
<tr>
<th>Cat</th>
<th>Proven calculi in ureter with</th>
<th>Proven calculi in kidney with</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>- 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</td>
<td>- resolved symptoms and/or - recurrent symptoms</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>- All staghorn stones</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Does the Patient meet the Minimum Referral Criteria?**

Please insert criteria into referral

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

2. **Type of Request** indicate on the referral
   - 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**

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

**Useful information, where available**

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

---

SEND REFERRAL
# 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**

### 1. Pre-Requisite Information

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

### 2. Type of Request

- 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**

- 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