Department of Health clinical urgency categories for specialist clinics
Urgent: A referral is urgent if the patient has a condition that has major functional impairment and/or moderate risk of permanent damage to an organ/bone/tissue/system if not seen within 30 days.
Semi Urgent: Referrals should be categorised as Semi Urgent where the patient has a condition that has the potential to deteriorate within 30-90 days.
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.
Exclusions: The following conditions should not be referred to outpatients, but rather patients should be advise to present directly to A&E: 'Active haematemesis and/or melaena; Acute severe colitis; Jaundice with fever / abdominal pain, Food bolus obstruction, Suspected bowel obstruction Decompensated cirrhosis with encephalopathy, jaundice or sepsis; Clinically significant ascites/hepatic hydrothorax'. Patients with Hepatocellular Carcinoma should not be referred to outpatients or present to A&E, rather referred directly to the Hepatocellular Carcinoma Unit. See Referral Form and Referral Guidelines.

These guidelines have been set by DHHS: src.health.vic.gov.au

Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes
Abnormal liver function tests Direct to Emergency Department for: • **Acute liver failure** • **Severe hepatic encephalopathy** • **Aspartate transaminase (AST) > 2,000 U/L.**	1. Features suggestive of cirrhosis: • platelet count < 120 x 10^9 per litre • splenomegaly • ascites • hepatic encephalopathy 2. Genetic haemochromatosis (C282Y homozygotes and C282Y/H63D compound heterozygotes only) 3. Abnormal liver function test with aspartate transaminase (AST) or alanine aminotransferase (ALT) ≥ 5 times the	Must be provided: 1. History of alcohol intake 2. History of injectable drug use 3. Current and historical liver function tests 4. Full blood examination 5. International normalised ration (INR) result 6. Urea and electrolytes 7. Upper abdominal ultrasound results 8. Hepatitis B virus and Hepatitis C virus serology results 9. History of diabetes 10. Iron studies 11. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available:	**Urgent if aspartate transaminase (AST) or alanine aminotransferase (ALT) ≥ 5 times the upper level of the normal range** **Routine otherwise**	

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	upper level of the normal range 1. Two abnormal liver function test results performed at least 3 months apart with aspartate transaminase (AST) or alanine aminotransferase (ALT) 2-5 times the upper level of the normal range. Referral not appropriate for: 1. Fatty liver with normal liver function tests.	1. Height, weight and body mass index 2. Any relevant family history.		
Chronic refractory constipation Direct to Emergency Department for: • **Suspected large bowel obstruction** • **Faecal impaction that has not responded to adequate medical management.** Additional comments: 1. The referral should note that the request is for advice on, or review of, the current management plan as requests for a second opinion will usually not be accepted.	1. Constipation lasting more than 12 months with refractory symptoms that affect the person's activities of daily living despite an adequate trial of treatment. Referral not appropriate for: 1. Patients with no sentinel findings, who have not had an adequate trial of treatment (e.g. regular osmotic laxatives) 2. Laxative dependence.	Must be provided: 1. Onset, characteristics and duration of symptoms 2. Details of previous medical management including the course of treatment and outcome of treatment 3. Current and complete medication history (including non-prescription medicines, herbs and supplements) 4. Thyroid stimulating hormone levels 5. Serum calcium. Provide if available: 1. Current and previous colonoscopy results 2. Details of any previous gastroenterology assessments or opinions. 3. Current and previous imaging results.	**Routine**	

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2. See also: statewide referral criteria for Constipation with Sentinel Findings				
Chronic refractory diarrhoea Additional Comments: 1. The referral should note that the request is for advice on, or review of, the current management plan as requests for a second opinion will usually not be accepted. 2. See also: statewide referral criteria for Diarrhoea with sentinel findings	1. Chronic refractory diarrhoea lasting more than 6 months with refractory symptoms (following an adequate trial of treatment) that affect the person's activities of daily living. Referral not appropriate for: 1. Laxative dependence.	Must be provided: 1. Onset, characteristics and duration of symptoms 2. Details of previous medical management including the course of treatment and outcome of treatment 3. Details of any previous gastroenterology assessments or opinions 4. Previous histopathology results. Provide if available: 1. Full blood examination 2. Iron studies 3. Vitamin B12 and folate test results 4. 25-OH vitamin D results 5. Faecal calprotectin 6. Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) 7. Previous colonoscopy results.	**Routine**	
Cirrhosis Direct to Emergency Department for: • **Acute liver failure** • **Sepsis in a patient with cirrhosis** • **Severe hepatic**	1. Suspected cirrhosis suggested by one or more of the following: • evidence of cirrhosis on imaging • platelet count < 120 x 10^9 per litre	Must be provided: 1. History of alcohol intake 2. History of injectable drug use 3. Current and historical liver function tests 4. Full blood examination	**Urgent if hepatic encephalopathy, ascites or jaundice** **< 3 months otherwise**	

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encephalopathy • **Severe ascites restricting movement and breathing.**	• ascites • hepatic encephalopathy • AST to platelet ratio index (APRI) >2.0.	5. International normalised ration (INR) result 6. Urea and electrolytes 7. Upper abdominal ultrasound results 8. Hepatitis B virus and Hepatitis C virus serology results 9. History of diabetes 10. Iron studies 11. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available: 1. Height, weight and body mass index.		
Coeliac disease	1. Positive coeliac serology 2. Advice on, or review of, symptomatic coeliac disease (previous histological diagnosis) not responding to dietary and medical management. Referral not appropriate for: 1. Positive coeliac gene test without positive coeliac serology.	Must be provided: 1. Coeliac serology results or previous histology results 2. Full blood examination 3. Iron studies. Provide if available: 1. Gastrointestinal symptoms (e.g. diarrhoea, weight loss) 2. Previous gastroscopy results 3. Previous histology results 4. Previous gastroenterology assessments or opinions 5. Urea and electrolytes 6. Liver function tests 7. Details of previous medical management including the course of treatment and outcome of treatment 8. Details of any other autoimmune conditions.	**<3 months**	GP Management: If coeliac disease confirmed (positive serology and abnormal small bowel biopsy), refer to a dietitian for gluten-free diet. If diagnostic uncertainty await specialist clinic appointment before commencing gluten free diet.

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Constipation with sentinel findings Direct to Emergency Department for: • **Suspected large bowel obstruction** • **Faecal impaction that has not responded to adequate medical management.** Additional Comments: 1. As part of the referral assessment, patients may be triaged by phone direct to colonoscopy	1. Constipation in patients with a duration of more than 6 weeks but less than 12 months, with any of the following: • >40 years of age • rectal bleeding • positive faecal occult blood test • weight loss (≥ 5% of body weight in previous 6 months) • abdominal or rectal mass • iron deficiency that persists despite correction of causative factors • patient or family history of bowel cancer (first degree relative < 55 years). Referral not appropriate for: 1. Patients with more than 12 months of symptoms, with no sentinel findings, who have not had an adequate trial of treatment.	Must be provided: 1. Onset, characteristics and duration of constipation and sentinel findings 2. Current and previous colonoscopy results 3. Full blood examination 4. Iron studies Provide if available 1. Current and previous histology results 2. Details of any previous gastroenterology assessments or opinions 3. Faecal occult blood test 4. Thyroid stimulating hormone levels	**Urgent**	Patients with positive faecal occult blood test may be triaged to colonoscopy prior to the appointment at a specialist clinic.
Diarrhoea with sentinel findings Direct to Emergency Department for:	1. Diarrhoea > 2 weeks but < 6 months duration, affecting activities of daily living, with one or	Must be provided: 1. Frequency and duration of diarrhoea	**Urgent**	GP Management: ***When to Refer:***

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• **Severe diarrhoea with dehydration or when the person is systemically unwell.** • **Bloody diarrhoea > 2 weeks** Additional Comments: 1. See also: statewide referral criteria for inflammatory bowel disease 2. See also: statewide referral criteria for chronic refractory diarrhoea	more of the following: • bloody diarrhoea • nocturnal diarrhoea • weight loss (≥ 5% of body weight in previous 6 months) • abdominal or rectal mass • inflammatory markers in the blood or stool • iron deficiency that persists despite correction of potential causative factors. Referral not appropriate for: 1. Diarrhoea < 4 weeks duration without sentinel findings.	2. Onset, characteristics and duration of sentinel findings (e.g. erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), faecal microscopy and culture and Clostridium difficile toxin) 3. Previous colonoscopy results 4. Coeliac serology 5. Full blood examination 6. Liver function tests. Provide if available: 1. Previous histology results 2. Details of any previous gastroenterology assessments or opinions 3. Iron studies 4. Thyroid stimulating hormone levels 5. Faecal calprotectin 6. Faecal occult blood test 7. Recent travel history.		*> 6 – 8 weeks without blood* *>2 weeks with blood*
Dysphagia (gastroenterology) Direct to Emergency Department for: • **Progressively worsening oropharyngeal or throat dysphagia** • **Inability to swallow with drooling or pooling of saliva** • **Unresolved food bolus obstruction.**	1. Recent onset dysphagia with any of the following: • symptoms for less than 12 months • progressive symptoms • anaemia • haematemesis • weight loss (≥ 5% of body weight in previous 6 months) • painful swallowing • symptoms of aspiration	Must be provided: 1. History of dysphagia and other symptoms over time 2. Any previous gastroscopy or other relevant investigations. Provide if available 1. Barium swallow, relevant imaging or gastroscopy results.	**Urgent**	GP Management: • Almost all patients need gastroscopy

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Additional Comments: 1. Referrals for oropharyngeal dysphagia should be directed to an ENT service provided by the health service.	• previously resolved bolus obstruction. Referral not appropriate for: 1. Dysphagia that has persisted for more than 12 months with none of the following: • progressive symptoms • anaemia • weight loss • painful swallowing • aspiration • previous resolved bolus obstruction.			
Gastroesophageal reflux Direct to Emergency Department for: • **Potentially life-threatening symptoms suggestive of acute severe upper gastrointestinal tract bleeding.**	1. Recent onset, persistent symptoms of gastroesophageal reflux with any one of: • unintended weight loss (≥ 5% of body weight in previous 6 months) • dysphagia • vomiting • iron deficiency that persists despite correction of potential causative factors. 2. Surveillance for previously diagnosed Barrett's oesophagus. Referral not appropriate for: 1. Patients with gastroesophageal reflux and no additional symptoms 2. Patients with controlled	Must be provided: 1. Onset, characteristics and duration of sentinel findings e.g. changes in weight, ferritin levels 2. Previous endoscopy results 3. Current and complete medication history (including non-prescription medicines, herbs and supplements).	**Urgent if patient >54 years** **Routine otherwise**	GP Management: When to Refer: Symptoms persisting despite lifestyle advice/acid reduction therapy New reflux in an older person

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	symptoms following lifestyle advice/acid reduction therapy 3. Patients that cease treatment and symptoms return 4. Uncomplicated hiatus hernia 5. Belching 6. Halitosis 7. Screening for Barrett's oesophagus in patients with gastroesophageal reflux without additional symptoms.			
Hepatitis B Direct to Emergency Department for: • **Acute liver failure** • **Sepsis in a patient with cirrhosis** • **Severe hepatic encephalopathy** • **Severe ascites restricting movement and breathing.** Additional comments: 1. Assessment and management of pregnant women with chronic hepatitis B may be undertaken as part of perinatal care at an appropriate institution eg Mercy Perinatal Clinic	1. Patients who are hepatitis B surface antigen (HbsAg) positive 2. Pregnant women who are hepatitis B surface antigen (HbsAg) positive 3. Patients who are immunosuppressed or starting immunosuppressant medicines who are hepatitis B core antibody (HbcAb) positive (e.g. transplant patients, starting chemotherapy). Referral not appropriate for: 1. Patients who are hepatitis B surface antigen (HbsAg) negative, unless they are immunosuppressed or starting	Must be provided: 1. Hepatitis B virus (HBV) serology results – including Hep B sAg, Hep B sAb, Hep B e serology. 2. Hepatitis B PCR viral load 3. Hepatitis C virus and HIV serology 4. Liver function tests 5. Full blood examination 6. If pregnant, gestational age 7. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available 1. Upper abdominal ultrasound results 2. Previous liver biopsy results 3. Details of previous medical management including the course of treatment and outcome of treatment.	**Routine**	GP Management: GPs play an important role in diagnosis, education and monitoring of chronic hepatitis B – shared care models may be recommended Selected patients may be appropriate to refer to S100 GP prescriber – to locate please check ASHM website. Chronic infection requires life-long follow-up, including 6-12 monthly hepatitis B monitoring, yearly hepatitis B DNA viral load, liver function testing and antiviral therapy if indicated Certain populations with chronic hepatitis B require lifelong monitoring for hepatocellular carcinoma with ultrasound and

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	immunosuppressant medicines and are hepatitis B core antibody (HbcAb) positive.			AFP every 6 months
Hepatitis C Direct to Emergency Department for: • **Acute liver failure** • **Sepsis in a patient with cirrhosis** • **Severe hepatic encephalopathy** • **Severe ascites restricting movement and breathing.**	1. Patients who are hepatitis C (HCV) RNA positive unable to be managed and treated in community-based services. 2. Patients who have hepatitis C and cirrhosis. Referral not appropriate for: 1. Hepatitis C should be managed and treated through suitable community-based services wherever possible 2. Patients who are hepatitis C (HCV) RNA negative who are not at ongoing risk of cirrhosis.	Must be provided: 1. Hepatitis C virus serology, genotype and RNA results 2. Hepatitis B virus serology results 3. HIV serology results 4. Liver function tests including aspartate transaminase (AST) 5. Full blood examination 6. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available 1. Upper abdominal ultrasound results 2. Previous liver biopsy results 3. Details of previous medical management including the course of treatment and outcome of treatment 4. History of alcohol intake 5. History of injectable drug use, including if the patient is still injecting.	**Routine** **Patients may be offered appointment at community-based Austin Health clinics if appropriate**	For additional details on our hepatitis C community clinic please see: https://www.austin.org.au/HepC/
Inflammatory bowel disease Direct to Emergency Department for: • **Acute severe colitis:**	1. Known inflammatory bowel disease. 2. Strongly suspected inflammatory disease based on:	Must be provided: 1. Current and previous colonoscopy results. 2. Current and previous imaging results. 3. Inflammatory marker result (erythrocyte sedimentation	**Routine**	•

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patients with ≥ 6 bloody bowel motions per 24 hours plus at least one of the following: ○ **temperature > 37.8°C** ○ **pulse rate > 90 bpm** ○ **haemoglobin < 105 gm/L** ○ **raised inflammatory markers (erythrocyte sedimentation rate (ESR) > 30 mm/hr or C-reactive protein (CRP) > 30 mg/L)** • **Suspected or known Crohn's disease with acute complications:** ○ **bowel obstruction** ○ **sepsis or intra-abdominal or pelvic abscess**. Additional Comments: 1. See also: statewide referral criteria for symptoms such as diarrhoea or abnormal imaging or colonoscopy results	• recurrent perianal fistulas or abscesses • imaging results that strongly suggest Crohn's disease or colitis • endoscopy findings consistent with inflammatory bowel disease.	rate (ESR) or C-reactive protein (CRP)). 4. Full blood examination. 5. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available 1. Faecal calprotectin.		
Persistent iron				

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Condition / Symptom	**Criteria for Referral**	**Information to be included**	**Expected Triage Outcome**	**Austin Specific Guidance Notes**
deficiency Direct to Emergency Department for: • **Shortness of breath or chest pain, syncope or pre-syncope with iron deficiency anaemia (ferritin below the lower limit of normal).** Additional Comments: 1. Referrals for iron deficiency related to persistent, heavy menstrual bleeding should be made to suitable community-based services wherever possible (see 1800 My Options). Where this is not practicable, referrals should be directed to a gynaecology service provided by the health service.	1. Persistent iron deficiency in men and post-menopausal women with either: • ferritin < 30 µg/L • ferritin 30-100 µg/L in the presence of inflammation (e.g. C-reactive protein (CRP) ≥ 5 mg/L) 2. Iron deficiency that persists despite correction of potential causative factors 3. Iron deficiency anaemia in pre-menopausal women: • with positive coeliac serology • with positive faecal occult blood test • that persists despite treatment of menorrhagia, with good cycle control. Referral not appropriate for: 1. Iron deficiency in pre-menopausal women with: • no positive coeliac serology • negative faecal occult blood test • managed menorrhagia and with good cycle control 2. Isolated low serum iron 3. Non-iron deficiency anaemia without evidence of blood loss	Must be provided: 1. History of menorrhagia 2. Dietary history, including red meat intake 3. Iron studies or serum ferritin 4. Full blood examination 5. Coeliac serology results 6. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available 1. Faecal occult blood test 2. Faecal calprotectin 3. Any family history of gastrointestinal cancer.	**Urgent**	Patients may be seen in General Gastroenterology or Iron Deficiency Clinic

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	4. Vegetarian diet without iron supplementation.			
Rectal bleeding Direct to Emergency Department for: • **Potentially life-threatening symptoms suggestive of acute severe lower gastrointestinal tract bleeding.** Additional Comments: Referrals for severe haemorrhoids should be directed to colorectal service provided by the health service.	1. Rectal bleeding in patients with any of the following: • 40 years or older • unintended weight loss (≥ 5% of body weight in previous 6 months) • abdominal or rectal mass • recent change in bowel habits • iron deficiency that persists despite correction of potential causative factors • patient or family history of bowel cancer (first degree relative < 55 years). Referral not appropriate for: 1. Persistent but unchanged symptoms previously investigated 2. If the patient has had a full colonoscopy in the last 2 years for the same symptoms 3. Untreated anal fissures 4. Bleeding is known to be coming from haemorrhoids.	Must be provided: 1. Onset, characteristics and duration of symptoms 2. Full blood examination 3. Urea and electrolytes 4. Iron studies 5. Previous and current gastrointestinal investigations and results 6. Patient age 7. Details of relevant family history of gastrointestinal or colorectal cancers. Provide if available 2. Current and previous colonoscopy results.	**Urgent**	

Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes
Dyspepsia **Epigastric pain**	Persistent dyspepsia despite PPI therapy and/or dietary advice and any one of: 1. Unintended weight loss (≥ 5% of body weight in previous 6 months) 2. Iron deficiency 3. Previously diagnosed atrophic gastritis 4. Previously diagnosed intestinal metaplasia/gastric dysplasia 5. Family history of upper GI cancer in first degree relative	Must be provided: 1. Onset, characteristics and duration of sentinel findings e.g. changes in weight, ferritin levels 2. Previous endoscopy and histopathology results 3. Current and complete medication history (including non-prescription medicines, herbs and supplements).	**Urgent:** - Age > 54 **Routine:** - Age < 55	

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Surveillance of colorectal polyps 1. Information on surveillance intervals of colorectal polyps can be found on Cancer Council Australia website 2. Ongoing surveillance of colorectal polyps is not indicated in patients of advanced age (>80 years or >75 years with significant comorbidities) – refer to Cancer Council Australia website for details.	1. History of adenomatous or sessile serrated polyps	Must be provided: **1.** Previous colonoscopy results including histology if relevant 2. Past medical history and medications including blood thinners	Routine Select patients may be triaged directly to colonoscopy	
Irritable Bowel Syndrome	1. Exclude clinical alarms: a. Symptoms < 6m b. Rectal bleeding c. Weight loss d. Abdominal mass e. Abnormal investigations 2. Ensure cancer screening up to date 3. Failure of initial management eg fibre supplementation, dietary modification, psychological therapies	Must be provided: 1. Onset, characteristics and duration of symptoms 2. Details of previous medical management including the course of treatment and outcome of treatment 3. Details of any previous gastroenterology assessments or opinions Provide if available: 1. Full blood count 2. Coeliac serology 3. Faecal calprotectin 4. Cancer screening results eg FOBT	**Urgent if any clinical alarms present** **Otherwise routine**	GP resources can be found at: www.ibs4gps.com

Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes
Family history of bowel cancer 1. Information on risk categorisation of people with a family history of colorectal cancer can be found on Cancer Council Australia website	Referral for colonoscopy appropriate for any of: 1. A first-degree relative with colorectal cancer diagnosed under 55 years 2. At least two first-degree relatives with colorectal cancer diagnosed at any age 3. One first-degree relative and at least two second-degree relative with colorectal cancer diagnosed at any age Referral not appropriate for the following risk category 1 people who should be screened with FOBT every 2 years: 4. No first or second degree relative with bowel cancer 5. One first-degree relative with colorectal cancer diagnosed at 55 years or older 6. One first-degree and one second-degree with colorectal cancer diagnosed at 55 years or older	Must be provided: 2. Details of relevant family history that meets criteria 3. Any previous colonoscopy results including histology if relevant 4. Past medical history and medications including blood thinners	**Routine** **Select patients may be triaged by phone directly to colonoscopy**	

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Unexplained weight loss	Referral appropriate for unexplained weight loss (≥ 5% of body weight in previous 6 months) and any of: 1. Gastrointestinal symptoms (rectal bleeding, altered bowel habit, unexplained abdominal pain) 2. Positive FOBT 3. Anaemia 4. Abnormal imaging suggestive of pathology of the gastrointestinal tract	Must be provided: 1. Onset, characteristics and duration of sentinel findings e.g. changes in weight, ferritin levels 2. FOBT results 3. Relevant imaging findings 4. Current and complete medication history (including non-prescription medicines, herbs and supplements).	**Urgent**	