Monash Health Referral Guidelines
NEPHROLOGY

EXCLUSIONS

Services not offered by Monash Health

Simple Renal Stones, Renal Cell Carcinoma - Refer to Urology Referral Guidelines
Patients under 18 years: Click here for Monash Children's Nephrology guidelines

CONDITIONS

Diabetic Nephropathy

Adult Polycystic Kidney Disease

GENERAL NEPHROLOGY
- Hypertension
- Recurrent Renal Stone Disease
- Recurrent Urinary Tract Infections
- Reflux

RENAL FAILURE
- Acute Renal Failure (or AKI: Acute Kidney Injury)
- Chronic Renal Failure
- Existing Dialysis Patient

GLOMERULONEPHRITIS
- Acute Glomerulonephritis
- Chronic Glomerulonephritis

Renovascular Disease

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit:	Program Director:	Last updated:
Professor Peter Kerr	Prof. Bill Sievert	25/09/2018

Monash Health Referral Guidelines
NEPHROLOGY

REFERRAL

How to refer to Monash Health

Mandatory referral content

Demographic:
Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details
including **provider number**
Usual GP (if different)
Interpreter requirements

Clinical:
Reason for referral
Duration of symptoms
Management to date and response to treatment
Past medical history
Current medications and medication history if relevant
Functional status
Psychosocial history
Dietary status
Family history
Diagnostics as per referral guidelines
Suitability for Telehealth

Click here to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact on call registrar on 9594-6666 and ask for “On-Call Renal Registrar”.

General enquiries

Phone: 1300 342 273

Submit a fax referral

Fax referral form to Specialist Consulting Services: 9594 2273

Head of unit: Professor Peter Kerr

Program Director: Prof. Bill Sievert

Last updated: 25/09/2018

DIABETIC NEPHROPATHY

DIABETIC NEPHROPATHY

Initial GP Work Up

- Standard history and examination

Investigations:

- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose, HbA1c
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- 24 hr urine for creatinine clearance and protein excretion as appropriate
- Renal ultrasound

Management Options for GP

Use of ACE-I or ARB

WHEN TO REFER?

Emergency

A rapid rise in creatinine levels (>25% in days-weeks) should prompt urgent action.

Urgent

- Heavy proteinuria (>3-5gm/day) or significant clinical nephrosis should prompt urgent referral.
- A rise in serumcreatinine >25% over weeks-months.

Routine

- Proteinuria < 3gm/day
- Abnormal but slowly changing renal function

BACK

GENERAL NEPHROLOGY

HYPERTENSION

Initial GP Work Up

- Standard history and examination

Investigations:

- UECs
- FBE
- Glucose
- LFTs, Ca, Phos
- Renal US & Doppler or other imaging
- MSU – M&C

Management Options for GP

- Routine antihypertensives

WHEN TO REFER?

Emergency

- BP > 200/110
- OR associated rapidly developing renal failure

Urgent

- BP persistently > 180/100
- Associated renal abnormalities such as heavy proteinuria or declining function

Routine

All other cases, including suspected renal artery stenosis and hyperaldosteronism.

BACK

GENERAL NEPHROLOGY (cont'd)

RECURRENT RENAL STONE DISEASE

Initial GP Work Up

- Standard history and examination

Investigations:

- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate, PTH
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- 24 hr urine for creatinine clearance and protein excretion as well as Ca excretion
- Renal ultrasound

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Bilateral obstruction (or unilateral in single kidney) with acute functional decline.

Urgent

Uncontrolled pain – refer to Urology

Routine

Most stone disease is longstanding.

BACK

RECURRENT URINARY TRACT INFECTIONS

Initial GP Work Up

- Standard history and examination

Investigations:

- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU – x2 (at least), including sensitivities
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- Renal ultrasound or other imaging

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Sepsis with clinical instability

Urgent

Persistent infections

Routine

Greater than 5 UTIs or 3 per year over consecutive years.

BACK

GENERAL NEPHROLOGY (cont'd)

REFLUX NEPHROPATHY

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination

Investigations:
- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- Renal ultrasound and Doppler

Management Options for GP
N/A

Emergency

Sepsis with clinical instability or acute renal functional decline.

Urgent
- Frequent, recurrent UTIs or deteriorating renal function.
- Heavy proteinuria.

Routine

All other cases.

BACK

GLOMERULONEPHRITIS

ACUTE GLOMERULONEPHRITIS

WHEN TO REFER?

Initial GP Work Up
- Presentation: Acute, chronic
- Standard history and examination

Investigations:
- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- ANA, dsDNA, ANCA, antiGBM, Complements – for acute cases
- 24 hr urine for creatinine clearance and protein excretion as appropriate
- Renal ultrasound

Management Options for GP
N/A

Emergency
- Rapidly deteriorating renal function or uncontrolled clinical nephrosis.
- Associated severe hypertension.

Urgent
- Nephrotic syndrome
- Declining renal function

Routine
- Non-nephrotic proteinuria (< 3gm/day)
- Stable renal function

BACK

GLOMERULONEPHRITIS (cont'd)

CHRONIC GLOMERULONEPHRITIS

Initial GP Work Up

- Presentation: Acute, chronic
- Standard history and examination

Investigations:

- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- ANA, dsDNA, ANCA, antiGBM, Complements – for acute cases
- 24 hr urine for creatinine clearance and protein excretion as appropriate
- Renal ultrasound

Management Options for GP

N/A

WHEN TO REFER?

Emergency

- Serum creatinine > 500 umol/l
- Uncontrolled fluid retention

Urgent

Serum Creatinine > 300umol/l

Routine

All other cases.

BACK

POLYCYSTIC KIDNEY DISEASE

ADULT POLYCYSTIC KIDNEY DISEASE

Initial GP Work Up

- Standard history and examination
- Family History

Investigations:

- FBE/ESR
- UEC's,
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- Renal ultrasound
- Consider cerebral MRA to exclude aneurysm

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Associated urinary sepsis

Urgent

Associated pain, infection or rapid decline in renal function.

Routine

All other cases.

BACK

RENAL FAILURE

ACUTE RENAL FAILURE (OR AKI: ACUTE KIDNEY INJURY)

WHEN TO REFER?

Initial GP Work Up:
- History and examination
- Drug history
- Contrast exposure

Investigations:
- UECs
- FBE/ESR
- LFTs, Ca, Phos
- Spot urine – alb/Cr or prot/Cr
- MSU – M&C
- Renal imaging (eg. US, to avoid contrast)

Emergency
- 30% rise in serum Creatinine over days
- Hyperkalaemia (> 6.0 mmol/l)
- Oligo-anuria

Urgent
- Slow rise in creatinine
- Fluid control difficulties
- Electrolyte abnormalities

Management Options for GP
N/A

BACK

CHRONIC RENAL FAILURE

WHEN TO REFER?

Initial GP Work Up
- Presentation: Existing dialysis patients or chronic renal failure - CKD stages 4 or 5. This equates to an eGFR of less than 30 ml/min or
- Standard history and examination
- History of diabetes and hypertension is particularly important

Investigations:
- FBE
- UECs
- LFTs
- Ca, Phos, PTH
- Iron stores
- MSU
- Renal ultrasound

Emergency
- Untreated CKD, creatinine > 700 umol/l
- Anuria
- Severe electrolyte abnormalities

Urgent
- Untreated Creatinine > 500 umol/l
- Fluid retention

Routine
All other cases

Management Options for GP
N/A

BACK

RENAL FAILURE (cont'd)

EXISTING DIALYSIS PATIENT

Initial GP Work Up

- Usually these patients are already under the care of the renal unit.
- Please refer new patients (eg. that have moved into the area), OR
- Those developing a new problem.

Investigations:
These are routinely performed by the Dialysis Units
If concerned:

- UECs
- LFTs, Ca, Phos
- FBE

Management Options for GP

- Limited – dialysis is often the only option
- Diuretics offer very limited benefit in fluid overload.

WHEN TO REFER?

Emergency

- AV-fistula clotted
- Sepsis, including PD-peritonitis
- Severe fluid retention

Urgent

All new cases

BACK

RENOVASCULAR DISEASE

RENOVASCULAR DISEASE

Initial GP Work Up

- Presentation: Other atherosclerotic disease, severe hypertension
- Standard history and examination

Investigations:

- FBE/ESR
- UEC's
- Albumin, total protein
- Calcium, phosphate
- Glucose
- MSU - Morphology and cast examination
- Spot urine for Alb/Creatinine ratio or Prot/Creatinine ratio
- Renal ultrasound

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Associated acute renal failure or severe hypertension

Routine

All other cases

BACK