Monash Health Referral Guidelines
RESPIRATORY

EXCLUSIONS

Services not offered by Monash Health

Patients under 18 years of age: Click here for Monash Children's Respiratory and Sleep Medicine guidelines

CONDITIONS

AIRWAY DISEASE
- Bronchiectasis
- Asthma
- Chronic Obstructive Pulmonary Disease

PARENCHYMAL - LUNG DISEASE
- Pulmonary Fibrosis
- Sarcoidosis
- Other Intestinal Lung Disease (see Pulmonary Fibrosis)

INFECTION - LUNG
- Respiratory Tract Infection
- Pneumonia / Lower Respiratory Tract Infection

PLEURAL
- Pleural Effusion
- Pneumothorax
- Pleural Plaques

NEOPLASIA - LUNG
- Mesothelioma
- Lung Cancer
- Lung Nodules

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: Professor Philip Bardin

Program Director: A/Professor Andrew Block

Last updated: 12/04/2019

Monash Health Referral Guidelines
RESPIRATORY

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
Past medical history
Current medications
Family history
Diagnostics as per referral guidelines

Click here to download the outpatient referral form

CONTACT US

Medical practitioners
To discuss complex & urgent referrals contact on call registrar via the Monash Health switchboard on: 9594 6666

General enquiries
Phone: 1300 342 273

Submit a fax referral
Fax referral form to Specialist Consulting Services: 9594 2273

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AIRWAY DISEASE

BRONCHIECTASIS

Initial GP Work Up

Patient history:

- Should be considered in anyone with chronic or recurrent purulent sputum. Quantitate phlegm production when well and when ill.
- Past history of severe respiratory infection usually in childhood e.g. Whooping Cough.
- History of Asthma

Investigations:

- Spirometry with reversibility
- Chest X-ray
- HRCT Lungs, but not during an exacerbation
- FBC, ESR
- Sputum culture when patient otherwise well and with exacerbations
- Assess for sinus disease

Management Options for GP

- Maintenance treatment: sputum clearance techniques are the cornerstone of long term management (to be referred to physiotherapist for education but not before CT scan).
- Long term antibiotics in consultation with Respiratory Physician.
- Fluvax and Pneumovax.
- Treatment of non-infective airways disease i.e. co-existing COPD and asthma should be considered. See below.
- Management of acute infective exacerbations e.g. acute bronchitis, pneumonia.
- Management in the community: antibiotics preferably post sputum culture/sensitivity. See Australian Antibiotic Guidelines.
- Manage co-existent acute / chronic sinusitis

WHEN TO REFER?

Emergency

Patient with diagnosis of severe Bronchiectasis

Urgent

Specialist assessment and management required for patients suspected of having Bronchiectasis

BACK

AIRWAY DISEASE (cont'd)

ASTHMA

Initial GP Work Up

Patient history:
- Breathlessness, tightness, wheezing and cough
- Recognition of severity

Investigations:
- Spirometry with bronchodilator reversibility
- FBE, IgE

Management Options for GP

Severe:
- High flow oxygen, IV/oral steroids, nebulised beta agonists. Transfer to ED by ambulance
- Consider Adrenaline 200 micrograms SC (= 2ml 1:10,000 or 0.2ml 1:1,000).

Mild to Moderate:
- Prednisone +/- inhaled steroids
- Beta agonists, short &/or long acting
- Education including smoking cessation, action plan etc
- The National Asthma Council handbook is an excellent free online resource.

WHEN TO REFER?

Emergency
- Acute moderate asthma not responding to GP management
- Acute severe asthma (via ambulance) e.g. coexistent pneumothorax or pneumonia, silent chest, cardiovascular compromise, altered consciousness, relative bradycardia or decreasing rate and depth of breathing
- Asthma with intercurrent disease e.g. Pneumonia

Urgent
- Asthma not readily controlled in GP setting
- Any feature of severe asthma (e.g. requiring frequent courses of prednisone)
- Frequent after hours attendance (ED or GP after hours service).
- Asthma with additional lung disease (e.g. Bronchiectasis, COPD)
- Asthma (i.e. uncertainty about diagnosis)
- Oral prednisolone requirements in community

BACK

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Initial GP Work Up

Patient history:
- History of smoking
- Exercise tolerance, functional capacity (ALDs)
- Cough and sputum
- R) heat failure
- Consider common co-morbidities: anxiety, depression, cardiovascular, osteoporosis

Investigations:
- Spirometry, reversibility, gas transfer
- Chest X-Ray
- FBE
- Sputum culture

Management Options for GP
- Smoking cessation
- Fluvax and Pneumovax
- Bronchodilators: LAMA, LABA, LAMA/LABA
- Inhaled steroids considered for frequent exacerbators, asthma overlap
- Optimise techniques of various drug delivery devices
- Ongoing monitoring
- Nutritional advice
- Pulmonary Rehabilitation – Physiotherapy

WHEN TO REFER?

Emergency
- Acute exacerbations
- Respiratory failure

Urgent
Specialist assessment and management required for:
- Patients with high symptom burden
- Pulmonary function testing
- Physiotherapy assessment/pulmonary rehab
- Frequent exacerbations
- Home oxygen assessment
- Right heart failure

Routine
Pulmonary function testing

BACK

INFECTION - LUNG

RESPIRATORY TRACT INFECTION

WHEN TO REFER?

Initial GP Work Up

Patient history:

- Smoking
- Inhalation of irritants
- Relevant past respiratory history e.g. asthma

Investigations:

- Chest X-Ray
- Sputum M & C

Management Options for GP

- Cessation of smoking
- Symptomatic treatment
- Broad spectrum antibiotics
- Consider flu vaccination for recurrent attacks

Emergency

- Refer for hospital admission for significant co-morbidities:
- Consider admission for significant co-morbidities

Routine

Specialist assessment and management not usually required

BACK

PNEUMONIA/LOWER RESPIRATORY TRACT INFECTION

WHEN TO REFER?

Initial GP Work Up

Patient history:

Standard history and examination with particular emphasis on the following:

- Respiratory rate, pulse, blood pressure and confusion
- Significant co-morbidities (diabetes, cardio-respiratory)
- Social circumstances

Investigations:

- Chest X-ray may be considered at presentation and 6-8 weeks post treatment
- Sputum M & C
- PBE, CRP

Management Options for GP

- Manage at home/community
- Appropriate broad spectrum antibiotics (see Therapeutic Guidelines)

Emergency

Features of sepsis / hypoxaemia

Urgent

- If Chest X-ray change unresolved
- Severe pneumonia (CURB65 or other scale)
- CURB65 score of 2 or more usually require hospital management
- Failure to resolve satisfactorily in the community

Routine

Follow up CXR particularly in smokers or history of malignancy

BACK

NEOPLASIA - LUNG

LUNG CANCER, MESOTHELIOMA

WHEN TO REFER?

Initial GP Work Up

Patient history:

- May be asymptomatic
- Most common symptoms if present are persistent cough, shortness of breath, chest pain, weight loss, and systemic symptoms.
- At risk group includes, among others:
  - Smokers or ex-smokers
  - Occupational exposures, particularly asbestos exposure (plumbers, builders, mechanics, ship engineers, railway engineers, wharfies, and truckies)

Investigations:

- Chest X-Ray
- CT Chest

Management Options for GP

N/A

Emergency

Significant breathlessness, significant haemoptysis or difficult to control pain.

Urgent

All suspected malignancy needs to be referred and reviewed within 2 weeks of initial referral.

Routine

Likely benign lung nodules are usually monitored for a period of time with serial imaging.

BACK

LUNG NODULES

WHEN TO REFER?

Initial GP Work Up

Patient history:

- Lung nodules are a frequent incidental finding on CT scans often in the absence of symptoms and can cause severe anxiety
- There are well defined society endorsed guidelines for the management and follow up/surveillance of these findings, see Fleischner Society Guidelines
- Smoking history - high index of suspicion malignancy

Investigations:

CT Chest

Management Options for GP

N/A

Urgent

Lung nodules ≥ 8mm or associated with suspicious features for malignancy

Routine

Nodules < 6mm are usually benign but need for surveillance can be further assessed by respiratory physician

BACK

PARENCHYMAL – LUNG DISEASE

PULMONARY FIBROSIS

Initial GP Work Up

Patient history;

- Breathlessness, dry cough, exercise intolerance
- Clubbing may be present
- Fine crackles on examination

Investigations:

- Restrictive spirometry, gas transfer
- Chest X-ray
- HRCT (non-contrast)
- Connective tissue disease screen: ANA, ENA, ESR, ANCA, dsDNA, anti-CCP and RF
- Occupational history: asbestos, silica dust, chemicals

Management Options for GP

May need bronchoscopic evaluation prior to treatment

WHEN TO REFER?

Emergency

- Acute ILD exacerbation can herald a rapid decline
- Usually managed in hospital

Urgent

Rapid referral for progressive decline in exercise tolerance

Routine

Urgent spirometry and non-contrast HRXT evaluation required for all suspected ILD patients

BACK

SARCOIDOSIS

Initial GP Work Up

Patient history:

Often asymptomatic (may present with respiratory or extrathoracic symptoms, e.g. skin, joints, eyes)

Investigations:

- Chest x-ray (changes compatible with diagnosis).
- ESR, Calcium, LFT, FBC
- ACE (debated utility)

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Exacerbation ILD or rapid progression of pulmonary or visual symptoms

Urgent

Progressive symptomatology

Routine

Lung function and initial review.

BACK

PLEURAL DISEASE

PLEURAL EFFUSION

WHEN TO REFER?

Emergency
Rapidly accumulating or significant symptomatology at rest

Urgent
Symptomatic large pleural effusion

Routine
All newly diagnosed effusions should be referred for investigation

Initial GP Work Up

Patient history:
Breathlessness and symptoms and signs of underlying condition e.g. heart failure, neoplasia and infection

Investigations:
- Chest x-ray
- LDH, FBE, total protein, LFTs
- Consider: echocardiogram if cardiac history or cardiac symptoms
- Consider :CT chest if features of malignancy or infection

Management Options for GP

N/A

BACK

PNEUMOTHORAX

WHEN TO REFER?

Emergency
All acute pneumothorax patients need emergency department assessment

Initial GP Work Up

Patient history:
Sudden onset of chest pain and/or breathlessness

Investigations:
Chest x-ray

Management Options for GP

Consider development of tension pneumothorax requiring immediate drainage. This is associated with haemodynamic compromise and is a medical emergency requiring intervention.

BACK

PLEURAL PLAQUES

WHEN TO REFER?

Urgent
Not required unless additional findings of ILD or pulmonary or pleural malignancy

Routine
Ongoing monitoring of pleural plaques is considered in selected patients

Initial GP Work Up

Patient history:
- History of asbestos exposure.
- At risk occupational groups include: plumbers, builders, mechanics, ship engineers, railway engineers, wharfies, and truckies

Investigations:
Chest x-ray

Management Options for GP

N/A

BACK