# Monash Health Referral Guidelines

## RESPIRATORY

### EXCLUSIONS

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

#### NEOPLASIA - LUNG
- Mesothelioma
- Lung Cancer
- Lung Nodules

#### PLEURAL
- Pleural Effusion
- Pneumothorax
- Pleural Plaques

### 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

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**Head of unit:**
Professor Philip Bardin

**Program Director:**
A/Professor Andrew Block

**Last updated:**
12/04/2019
Monash Health Referral Guidelines
RESPIRATORY

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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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)**

### 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

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**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
### RESPIRATORY TRACT INFECTION

**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

### WHEN TO REFER?

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

**Routine**
- Specialist assessment and management not usually required

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### PNEUMONIA/LOWER RESPIRATORY TRACT INFECTION

**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)

### WHEN TO REFER?

**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

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**INFECTION - LUNG**
LUNG CANCER, MESOTHELIOMA

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

WHEN TO REFER?

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.

LUNG NODULES

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

WHEN TO REFER?

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
### 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

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### 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.
PLEURAL EFFUSION

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

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

PLEURAL PLAQUES

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

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

PNEUMOTHORAX

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.

WHEN TO REFER?

Emergency
All acute pneumothorax patients need emergency department assessment

BACK