EXCLUSIONS

Services not offered by Monash Health Haematology

Children under the age of 16 – refer to [Monash Children’s Cancer Centre](#)

CONDITIONS

- Acute and Chronic Leukaemias
- Blood Film Abnormalities
- Lymphoma and Lymphadenopathy
- Paraproteinemia and Multiple Myeloma
- Thrombotic and Bleeding Disorders

General
- Iron Overload
- Iron Deficiency
- Polycythemia
- Thrombosis and Lymphocytosis

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: Prof Stephen Opat

Program Director: Prof William Sievert

Last updated: 27/06/2019
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
- Relevant pathology and imaging reports (refer to specific guidelines)
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Dietary status
- Family history
- Diagnostics as per referral guidelines

CONTACT US

Medical practitioners
To discuss complex & urgent referrals contact on call haematology registrar or consultant haematologist via 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

Click here to download the outpatient referral form. Incomplete referrals will be returned.

Head of unit: Prof Stephen Opat
Program Director: Prof William Sievert
Last updated: 27/06/2019
ACUTE AND CHRONIC LEUKAEMIA

Initial GP Work Up
- Full Blood Examination / Film
- Biochemistry including liver and renal function
- Iron Studies
- Serum Vitamin B12/ Holo TC
- LDH
- INR, APTT, fibrinogen

Management Options for GP
N/A

WHEN TO REFER?

Emergency
- All cases of suspected acute leukaemia should be discussed immediately with the haematology registrar or consultant haematologist on call (via Monash Health switchboard on 9594 6666) with consideration of direct admission or emergency department presentation.
- Acute leukaemia is not appropriate for an elective haematology clinical referral.

Urgent
Chronic leukaemia

BLOOD FILM ABNORMALITIES

ANAEMIA, NEUTROPENIA, THROMBOCYTOPENIA AND OTHER BLOOD FILM ABNORMALITIES

Initial GP Work Up
- Full Blood Examination
- Biochemistry including liver and renal function
- Folate and Iron Studies
- Serum Vitamin B12/ Holo TC
- Serum protein electrophoresis
- LDH
- INR, APTT, Fibrinogen
- Include reports of previous endoscopies with referral

Management Options for GP
Consider medications that might be contributing to condition and potential alternatives.

WHEN TO REFER?

Emergency
Patients with thrombocytopenia with a platelet count less than 20 x 10⁹/L

Urgent
- Patients with thrombocytopenia with a count less than 50 x 10⁹/L
- More than one abnormal result (eg neutropenia associated with anaemia and/or thrombocytopenia)

Routine
Most cases of anaemia with no other complications
LYMPHOMA AND LYMPHADENOPATHY

SUSPECTED AND/OR PROVEN LYMPHOMA AND INVESTIGATION OF LYMPHADENOPATHY

Initial GP Work Up
- Full Blood Examination / Film
- Biochemistry including liver and renal function, calcium
- LDH
- ESR, CRP
- PT/INR, APTT, Fibrinogen
- Results of any imaging performed

Management Options for GP
N/A

WHEN TO REFER?

Urgent
If suspected or proven lymphoma, contact on call haematology registrar or consultant haematologist via Monash Health switchboard on 9594 6666

PARAPROTEINEMIA AND MULTIPLE MYELOMA

PARAPROTEIN AND MULTIPLE MYELOMA

Initial GP Work Up
- Full Blood Examination / Film
- Biochemistry including liver and renal function and calcium studies
- Serum Protein Electrophoresis
- Serum Free Light Chains
- LDH
- Beta 2 Microglobulin
- Immunoglobulins
- Urinary Bence-Jones protein
- Urinary albumin-to-creatinine ratio
- Include results of radiological investigations (e.g. skeletal survey, MRI spine) if available

Management Options for GP
N/A

WHEN TO REFER?

Emergency
Contact on call haematology registrar or consultant haematologist via Monash Health switchboard on 9594 6666 or send direct to emergency if any life threatening or severe symptoms present eg:
- Recent unexplained mild to moderate renal impairment
- New hypercalcaemia
- Threatened spinal cord compromise
- New renal failure
- Hypercalcaemia

Urgent
- Recent onset unexplained anaemia
- Lytic bone lesions

Routine
Patient otherwise asymptomatic or well

BACK
THROMBOTIC AND BLEEDING DISORDERS

Initial GP Work Up
- INR, APTT, Fibrinogen
- Full Blood Examination / Film
- Biochemistry including liver and renal function
- Relevant diagnostics or follow up scans (VQ, CTPA, U/S)
- LDH

Management Options for GP
If pregnant, will require a joint approach between Haematologist, Obstetrician or Physician specialising in disorders of pregnancy

WHEN TO REFER?

Emergency
Acute bleeding should be referred for admission

Urgent
Acute thrombotic event

Routine
Assessment required prior to planned surgery or pregnancy

GENERAL

Initial GP Work Up
Full Blood Examination / Film

Management Options for GP
N/A

Routine
Likely routine unless otherwise indicated from pathology results
IRON OVERLOAD

Initial GP Work Up
• Ferritin, transferrin saturation
• Metabolic profile (e.g. fasting glucose, cholesterol, uric acid)
• HFE gene studies in selected cases (e.g. family history, metabolic hyperferritinaemia excluded).
• LFT’s
• Liver ultrasound

Management Options for GP
N/A

IRON DEFICIENCY

Initial GP Work Up
• Full Blood Examination, Iron studies, CRP, UEC, LFT, B12./ Holo TC, folate, reticulocytes, coeliac serology
• Consider 3 x faecal occult blood

Management Options for GP
• GI tract blood loss must be excluded in all cases of iron deficiency.
• Most iron deficiency does not require Specialist Haematology Assessment.
• Low B12 requires exclusion of pernicious anaemia and other causes of malabsorption.
• Gastroenterology referral should be considered
• Refer to Diagnosis and management of iron deficiency anaemia: a clinical update (Pasricha et al)

WHEN TO REFER?

Routine
Most referrals considered routine

WHEN TO REFER?

Routine
• Anaemia refractory to iron and B12/folate
• Persistent unexplained anaemia
POLYCYTHEMIA

Initial GP Work Up
- Full Blood Examination / Film,
- Iron Studies
- Erythropoietin levels (not MBS rebated – check with pathology provider regarding cost of test)
- JAK2 V617F molecular testing (MBS rebated)

Management Options for GP
- Exclude COPD and sleep apnoea
- Modify lifestyle factors (eg smoking)
- Consider contributing medications

WHEN TO REFER?

Urgent
- Hb > 200g/dl (PCV >0.60) in the absence of chronic hypoxia
- Raised Hb in association with:
  - Recent arterial or venous thrombosis
  - Neurological symptoms / visual loss
  - Abnormal bleeding

Routine
- Elevated PCV in association with:
  - Past history of arterial or venous thrombosis
  - Splenomegaly
  - Pruritus
  - Elevated white cell or platelet counts
- Persistent (at least on two occasions 4-6 weeks apart), unexplained elevated PCV

THROMBOCYTOSIS & LYMPHOCYTOSIS

Initial GP Work Up
- Full Blood Examination / Film,
- Iron Studies
- Inflammatory markers

Management Options for GP
N/A

WHEN TO REFER?

Urgent
- Lymphocytes >20x10^9/L or rapidly raising and:
  - Anaemia
  - Neutropenia
  - Thrombocytopenia
  - Progressive Lymphadenopathy
  - Unexplained weight loss
  - Night sweats
  - Evening temperature
  - Presence of suspicious cells / blasts on blood film
- Platelets >1000x10^9/L
- Platelets >450x10^9/L and:
  - Neurological symptoms
  - Abnormal bleeding
  - Recent thrombotic event

Routine
Refer to haematology if cause of thrombocytosis or lymphocytosis not identified