Monash Health Referral Guidelines

Incorporating Statewide Referral Criteria

Rheumatology

EXCLUSIONS

Services not offered by Monash Health

Management of cases with third-party payer involvement e.g. TAC, Workcover.
Patients under 18: Click here for Monash Children's Paediatric Rheumatology guidelines

CONDITIONS

INFLAMMATORY ARTHRITIS
Psoriatic Arthritis
Ankylosing spondylitis (Inflammatory back pain)
Inflammatory Arthritis
Crystal Arthritis (Gout)

CONNECTIVE TISSUE DISEASES & VASCULITIS
Systemic Lupus Erythematosus
Scleroderma
Vasculitis
Other connective tissue disease
Polymyalgia and Giant Cell Arthritis

NON-INFLAMMATORY BONE AND JOINT DISEASE
Back & Neck Pain
Soft tissue rheumatism (tendinitis, etc)
Osteoarthritis
Metabolic Bone Disease (Rheumatology)

MUSCULSKELETAL PAIN SYNDROMES
Fibromyalgia
Complex Regional Pain Syndromes

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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Program Director: Prof. William Sievert
Last updated: 06/11/2023

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REFERRAL

How to refer to Monash Health

Secure eReferral by HealthLink is now our preferred method of referral.

Find up-to-date information about how to send a referral to Monash Health on the **eReferrals page on our website**.

CONTACT US

Medical practitioners

To discuss complex & urgent referrals, contact on call registrar via Main Switchboard 9594 6666

General enquiries

Phone: 1300 342 273

INFLAMMATORY ARTHRITIS

PSORIATIC ARTHRITIS
(Psoriatic arthritis and seronegative spondyloarthropathies)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Suspected psoriatic arthritis with one or more of the following:
  - Mono, oligo, or polyarticular synovitis
  - Inflammatory back pain (morning stiffness, relief with use)
  - Heel pain (enthesitis)
  - Uveitis
  - Dactylitis
  - Psoriasis
  - Inflammatory bowel disease
  - Positive family history of spondyloarthritis
  - HLA-B27 positive.

Information to be included in the referral

Information that **must** be provided

- Description of joints affected and onset, characteristics and duration of symptoms
- Details of skin conditions
- Details of all sentinel findings
- Details of previous medical management including the course of treatment and outcome of treatment
- Full blood examination results
- Erythrocyte sedimentation rate (ESR)
- C-reactive protein (CRP)
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- If the patient is pregnant or planning a pregnancy.

Provide if available

- Rheumatoid factor (RhF) levels
- Anti-cyclic citrullinated peptide (anti-CCP) antibody levels
- Relevant x-rays including sacroiliac
- Liver function tests
- Urea and electrolyte results
- How symptoms are impacting on daily activities (e.g. work, study, or carer role)
- Previous rheumatology and dermatology assessments or opinions
- HLA-B27

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Patients with acutely painful, hot, swollen joint(s) especially if febrile
- Suspected sepsis in a patient with previously diagnosed psoriatic arthritis
- Unexplained illness or fever in a patient being treated with biologic or immunosuppressant medicines.

Urgent

Early institution of highly effective therapies is needed if high inflammatory burden evidenced by swollen joint count, CRP/ESR

Routine

- All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies
- Monash Psoriatic arthritis clinic runs in conjunction with dermatology clinic, allowing a single point of care

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

As psoriatic arthritis is chronic or progressive condition that requires ongoing specialist advice the referral should request partnership care between the patient, their general practitioner and the health service.

Continued over page

BACK

INFLAMMATORY ARTHRITIS

PSORIATIC ARTHRITIS
(Psoriatic arthritis and seronegative spondyloarthropathies) Continued

The referral should note if the request is for a second or subsequent opinion as requests for a second opinion will usually not be accepted.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Psoriatic arthritis

HealthPathways
Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

INFLAMMATORY ARTHRITIS

ANKYLOSING SPONDYLITIS (INFLAMMATORY BACK PAIN)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Inflammatory back pain (morning stiffness, relief with use) with onset of symptoms before 45 years, with more than 3 months of symptoms, with one or more of the following:
  - Heel pain (enthesitis)
  - Peripheral arthritis (mono, oligo, or polyarticular)
  - Dactylitis
  - Iritis or anterior uveitis
  - Psoriasis
  - Inflammatory bowel disease
  - Positive family history of axial spondyloarthritis, reactive arthritis, psoriasis, inflammatory bowel disease or anterior uveitis
  - Previous good response to non-steroidal anti-inflammatory medicines
  - Raised acute phase reactants (erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) or both)
  - HLA-B27 positive
  - Sacroiliitis shown on x-ray or MRI.

Information to be included in the referral

Information that **must** be provided

- Description of joints affected and onset, characteristics and duration of symptoms
- Details of all sentinel findings
- Report on x-ray that includes the sacroiliac joint
- Details of previous medical management including the course of treatment and outcome of treatment
- Full blood examination results
- Erythrocyte sedimentation rate (ESR)
- C-reactive protein (CRP)
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- If the patient is pregnant or planning a pregnancy.

Provide if available

- Reports of previous results of x-ray or imaging of the sacroiliac joint
- Liver function tests
- Urea and electrolyte results
- How symptoms are impacting on daily activities (e.g. work, study, or carer role)
- Previous rheumatology assessments or opinions.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- New neurological features in a patient with previously diagnosed ankylosing spondylitis
- Patients with acutely painful, hot, swollen joint(s) especially if febrile
- Suspected sepsis in a patient with previously diagnosed inflammatory back pain
- Unexplained illness or fever in a patient being treated with biologic or immunosuppressant medicines.

Urgent

Early institution of highly effective therapies is needed if high inflammatory burden evidenced by swollen joint count, CRP/ESR

Routine

- All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies
- Monash Psoriatic arthritis clinic runs in conjunction with dermatology clinic, allowing a single point of care

BACK

INFLAMMATORY ARTHRITIS

ANKYLOSING SPONDYLITIS (INFLAMMATORY BACK PAIN) (Psoriatic arthritis and seronegative spondyloarthropathies) Continued

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

As inflammatory back pain is chronic or progressive condition that requires ongoing specialist advice the referral should request partnership care between the patient, their general practitioner and the health service.

The referral should note if the request is for a second or subsequent opinion as requests for a second opinion will usually not be accepted.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Ankylosing spondylitis
Psoriatic arthritis

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

INFLAMMATORY ARTHRITIS

INFLAMMATORY ARTHRITIS (Rheumatoid arthritis and suspected inflammatory arthritis)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Suspected or diagnosed inflammatory arthritis (including psoriatic arthritis) morning stiffness, relieved with use, swollen joints with active symptoms
- Previously diagnosed inflammatory arthritis for review of management plan, monitoring or management of toxicity associated with treatment.

Information to be included in the referral

Information that **must** be provided

- Description of joints affected and onset, characteristics and duration of symptoms
- Details of previous medical management including the course of treatment and outcome of treatment
- Full blood examination
- Erythrocyte sedimentation rate (ESR)
- C-reactive protein (CRP)
- Details of skin conditions (if referral relates to psoriatic arthritis)
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- If the patient is pregnant or planning a pregnancy.

Provide if available

- Rheumatoid factor (RhF) levels
- Anti-cyclic citrullinated peptide (anti-CCP) antibody levels
- Relevant x-rays
- Liver function tests
- Urea and electrolyte results
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- How symptoms are impacting on daily activities (e.g. work, study, or carer role)
- Previous rheumatology assessments or opinions
- If symptoms are thought to be linked to probable or confirmed SARS CoV-2 (COVID-19) infection or Long COVID.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

As inflammatory arthritis is chronic or progressive condition that requires ongoing specialist advice the referral should request partnership care between the patient, their general practitioner and the health service.

WHEN TO REFER?

Emergency

Direct to an emergency department

- Patients with acutely painful, hot, swollen joint(s) especially if febrile
- Suspected sepsis in a patient with previously diagnosed rheumatoid arthritis
- Unexplained illness or fever in a patient being treated with biologic or immunosuppressant medicines.

Urgent

Early institution of highly effective therapies is needed if high inflammatory burden evidenced by swollen joint count, CRP/ESR

Routine

- All patients with chronic inflammatory arthritis require specialist assessment and management. Early correct diagnosis allows institution of highly effective therapies
- Monash has a dedicated RA clinic offering advanced therapies

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Inflammatory arthritis
Rheumatoid arthritis

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

INFLAMMATORY ARTHRITIS

CRYSTAL ARTHRITIS (GOUT) (Acute single joint inflammation – monoarthritis)

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Suspected gout in premenopausal women or men < 40 years
- Tophaceous gout with progressive joint damage, active symptoms or growing tophi despite medical management
- Gout that has previously been diagnosed with any of the following:
  - Allopurinol intolerance (e.g. rash, hepatitis)
  - Symptoms despite maximum tolerated allopurinol dosage
  - Progressive joint damage despite medical management
  - Compromised renal function: glomerular filtration rate (GFR) < 30 mL/min/1.73m^2
  - Solid organ transplant
  - Complex comorbidities.

Information to be included in the referral

Information that **must** be provided

- Description of joints affected and onset, characteristics and duration of symptoms
- Frequency of episodes and number of attacks that have occurred within the last 12 months
- Inter-episode blood uric acid levels
- Details of previous medical management including the course of treatment and outcome of treatment
- Relevant medical history
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Glomerular filtration rate (GFR).

Provide if available

- How symptoms are impacting on daily activities (e.g. work, study, or carer role)
- Full blood examination results
- Relevant x-rays
- Results of previous joint aspirations.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Patients with acutely painful, hot, swollen joint(s) especially if febrile.
- Suspected sepsis in a patient with previously diagnosed gout.
- Patients with acute inflammatory monoarthritis require joint aspiration for exclusion of bacterial infection

Routine

- Patients with gout should only be referred if multiple attacks, refractory to therapy
- Do not stop allopurinol therapy during an acute attack
- Target uric acid in lower half of normal range by escalating therapy per guidelines

Referral to a public hospital is not appropriate for

- Asymptomatic hyperuricaemia
- A single attack of gout
- Previously diagnosed gout that is adequately managed
- Recurrent episodes of gout without the use of rate lowering therapy.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Gout

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

CONNECTIVE TISSUE DISEASES & VASCULITIS

CONNECTIVE TISSUE DISEASES

- **Systemic lupus erythematosus** - multisystem inflammatory presentation often with arthritis, rash, anaemia, serositis, nephritis, CNS involvement
- **Scleroderma** (systemic sclerosis) - Raynaud's, dysphagia, skin tightening, telangiectasia
- **Vasculitis** - purpuric rash, nephritis, lung or ENT involvement, fever, constitutional features
- **Other Connective tissue disease** - features include Raynaud's phenomenon, rash, arthritis, serositis, myositis, proteinuria, sicca - with positive ANA

Initial GP Work Up

- Always check the urine and BP
- Nephritis can be rapidly progressive and requires urgent assessment
- Temporal arteritis can lead to blindness and must be assessed as an emergency
- Lab investigations which should be performed prior to referral include:
- ANA, DsDNA, ANCA
- MSU (urinalysis, M&C)
- FBE, ESR, U&E, CK, CXR

Management Options for GP

- Correct early diagnosis is essential
- Specific treatments depend on the specific problems identified; Immunosuppression is not required in all cases
- Life threatening complications include pulmonary arterial hypertension, interstitial lung disease, glomerulonephritis
- Scleroderma renal crisis presents with malignant hypertension and is an Emergency
- Management of cardiovascular risk factors is essential

WHEN TO REFER?

Emergency

- Acute vasculitis syndromes should be referred to ED or to Rheumatology Registrar immediately on suspicion
- If GCA is suspected please page the on-call rheumatology registrar for immediate assessment. Referral for outpatient management is not appropriate
- Scleroderma renal crisis presents with malignant hypertension and is an emergency. Patient should be urgently referred to the ED

Urgent

- Autoimmune diseases need careful diagnostic workup prior to initiation of therapy. Rapid assessment would be expedited by a call to the Rheumatology Registrar
- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review
- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review

Routine

- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease and such referrals will be rejected
- Monash Rheumatology provides a diagnostic service as well as management guidance. Patients with symptoms, or lab results, highly suggestive of SLE or a connective tissue disease, where a diagnostic opinion is required, may therefore also be referred
- Monash Lupus and Vasculitis clinics run in conjunction with nephrology, allowing a single point of care for each
- In suspected PMR, if symptoms are not immediately and completely relieved by low-dose prednisolone (15-20 mg/day), patient should be referred or diagnosis reconsidered

BACK

CONNECTIVE TISSUE DISEASES & VASCULITIS

POLYMYALGIA AND GIANT CELL ARTHRITIS

- Shoulder and hip girdle pain and stiffness
- Prominent early morning stiffness in the shoulder & hip girdle
- Headache with scalp tenderness, jaw claudication
- Visual loss (emergency)

Initial GP Work Up

- Raised ESR/CRP, normal CK

Management Options for GP

- PMR: therapeutic trial of medium dose Prednisone (15-20mg daily) for PMR can be considered. Immediate and complete resolution of symptoms is expected in PMR
- GCA: Symptoms of giant cell arteritis mandate urgency. Patient should be seen in Emergency Department for urgent biopsy and treatment
- A positive ANA in the absence of clinical features is unlikely to represent a significant immune disease

WHEN TO REFER?

Emergency

- Acute vasculitis syndromes should be referred to ED or to Rheumatology Registrar immediately on suspicion
- If GCA is suspected please page the on-call rheumatology registrar for immediate assessment. Referral for outpatient management is not appropriate
- Scleroderma renal crisis presents with malignant hypertension and is an emergency. Patient should be urgently referred to the ED

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- If suspected glomerulonephritis, pulmonary arterial hypertension, pericarditis, or interstitial lung disease, please page Rheumatology Registrar to arrange early review

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BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE

BACK AND NECK PAIN

- Acute back pain after causative event e.g. twisting injury
- Chronic back pain
- Radicular symptoms
- Limb motor or sensory findings
- Inflammatory back pain e.g. Spondyloarthropathy

Initial GP Work Up

- Are symptoms localised or is there referred pain?
- Neurological examination findings are required in the referral
- MRI scanning is not a routine part of the assessment of back pain at Monash Health
- 'Red flag' symptoms: weight loss, PR bleeding, night pain, fever/rigors, cough/haemoptysis, haematuria, history of or suggestive of malignancy
- Consider Blood tests: FBC, ESR, CRP, LFT, Ca++, myeloma screen
- Lab tests may be normal
- Plain radiographs of the spine are not indicated for most cases of back pain

Management Options for GP

- Consider simple analgesia or non steroidal inflammatories for symptom relief unless contraindicated
- Refer if significant referred pain or if any motor or sensory signs
- Most referrals for back pain require a physiotherapy/rehab approach, not medical therapy, unless there is diagnostic doubt. Consider a referral to a primary physiotherapy clinician instead of rheumatology.
- Monash Rheumatology **does not** have priority access to physiotherapy services.

WHEN TO REFER?

Emergency

Acute neurological signs (motor or sensory loss) should prompt early assessment, potentially via Emergency Department. If in doubt, please contact the Rheumatology Registrar for advice

Urgent

Presence of 'red flag' symptoms or nerve root symptoms should prompt early investigation and assessment.

Routine

- Few patients with back pain or sciatica need surgery
- Do not refer unless treatment by a physiotherapist has been unsuccessful as this is always the first line of therapy (excluding emergency and urgent cases as above)
- Wait times for non-urgent assessment are long; consider management in the community

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE

SOFT TISSUE RHEUMATISM

- Shoulder pain/Rotator cuff/Adhesive capsulitis
- Epicondylitis
- Trochanteric bursitis
- Carpal tunnel syndrome
- Plantar Fasciitis

Initial GP Work Up

- History: trauma, occupation, pain pattern
- Exam: swelling, crepitus, range of motion
- Investigations: FBC, ESR, XR, US (see below)

Management Options for GP

- Local injection therapy including imaging-guided if needed
- NSAID
- Physiotherapy of value especially ROM and strengthening exercises
- Shoulder US usually shows cuff degeneration in older people

WHEN TO REFER?

Urgent

Cases where life is severely impacted upon, eg work ability, may be seen more urgently if specified

Routine

Cases refractory to simple approaches including NSAID and steroid injection can be referred

BACK

OSTEOARTHRITIS

- Chronic joint pain
- Lack of inflammatory features

Initial GP Work Up

- Establish diagnosis
- Exclude inflammatory disease: CRP

Management Options for GP

- Education (Arthritis Foundation)
- Physical therapy
- Self management skills
- Orthotic assessment
- Simple analgesia

WHEN TO REFER?

Urgent

Cases where life is severely impacted upon, eg work ability, may be seen more urgently if specified

Routine

- Osteoarthritis is usually best managed in the community. When pain and loss of function become limiting, surgery is usually required (Orthopaedic referral). Rheumatology can offer help if the differential diagnosis is uncertain (eg overlapping inflammatory symptoms) or if surgery is medically contraindicated
- Intra-articular steroid injections and arthroscopy have been demonstrated to be ineffective in osteoarthritis; patients should generally not be referred in expectation of such interventions

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE

METABOLIC BONE DISEASE (RHEUMATOLOGY) WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic Services

- Suspected metabolic bone disease that is not osteoporosis (for example: Paget's disease, fibrous dysplasia, osteomalacia, osteogenesis imperfecta)
- Persistent osteoporosis despite maximum treatment
- Osteoporosis in women < 50 years or men < 60 years
- Intolerance to, or contraindication for, maximum treatment
- Metabolic bone disease associated with:
  - Treatment with glucocorticoid medicines
  - Inflammatory disorders
  - Chronic kidney disease
  - Post-transplant
- Metabolic bone disease associated with complications associated with treatment:
  - Atypical femoral fracture
  - Osteonecrosis of the jaw
- Advice on, or review of, management plan in patients with stable metabolic bone disease after 5 years of treatment.

Information to be included in the referral

Information that **must** be provided

- Details of all fractures, including location
- Details of previous medical management including the course of treatment and outcome of treatment
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Recent (in last 3 months)
  - Serum calcium result
  - Serum 25-hydroxy vitamin D (25(OH)D)
  - Phosphate blood test result
  - Creatinine and electrolytes result
  - Albumin blood test result
  - Alkaline phosphate (ALP) blood test result
- Relevant comorbidities.

Provide if available

- Current or previous bone densitometry results
- Current or previous radiological reports of any fractures
- Parathyroid (PTH) blood test result.

Continued over page

Routine

- Osteoporosis is usually best managed in the community. Management of complicated or atypical presentations, where conventional treatments are contraindicated or ineffective, can prompt referral.
- Monash Health also has dedicated Osteoporosis and Metabolic Bone Disease clinics

BACK

NON-INFLAMMATORY BONE AND JOINT DISEASE

METABOLIC BONE DISEASE (RHEUMATOLOGY) Continued

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals to a rheumatology service are most appropriate for:

- Metabolic bone disease associated with:
  - Treatment with glucocorticoid medicines
  - Inflammatory disorders
- Metabolic bone disease associated with complications of treatment:
  - Atypical femoral fracture
  - Osteonecrosis of the jaw.

Other referrals are likely to be directed to an alternative specialist clinic or service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for

- Osteoporosis that has not been treated
- Age appropriate osteopenia without fracture(s)
- When the person's life expectancy is < 6 months.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

INSERT SEMPHN PATHWAY

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

MUSCULOSKELETAL PAIN SYNDROMES

FIBROMYALGIA AND COMPLEX REGIONAL PAIN SYNDROMES

Initial GP Work Up

- Consider medical causes of fatigue, myalgia, e.g. hypothyroid, depression
- Exclude statin myopathy and Vitamin D deficiency as reversible causes
- History of trauma, sleep disturbance, psychosocial evaluation important
- Examination – tenderness to pressure in non-articular sites, tender points, pain behaviours
- Investigations - FBC/ESR/U&Es/Vit D/CK
- NB: FMS can exist with other conditions

Management Options for GP

- Explore psychosocial issues
- Increased aerobic fitness, especially with water-based exercise
- Emphasis on self management
- Involve multidisciplinary approach e.g. CBT via clinical psychologist
- Low dose tricyclic antidepressants / gapapentin/simple analgesia
- Avoid narcotic analgesia

WHEN TO REFER?

Routine

- Monash Rheumatology does not offer a multidisciplinary team for the care of fibromyalgia. Expert rheumatologists with a research interest in fibromyalgia staff a weekly fibromyalgia clinic for medical advice. Community based care is emphasised and most patients are returned to the community
- All rheumatologists can manage fibromyalgia. If fibromyalgia has been diagnosed by a rheumatologist, management by that rheumatologist rather than by Monash Health is recommended. Monash fibromyalgia clinic has very long wait times for new patients and does not offer ‘second opinion’ consultations

BACK