Monash Health Referral Guidelines
(Incorporating Statewide Referral Criteria)
VASCULAR SURGERY

EXCLUSIONS

Services not offered by Monash Health

- Incidental asymptomatic atherosclerotic plaque or stenosis. Please refer to Vascular Medicine for management of complex medical issues.
- Isolated external carotid artery stenosis
- Incidental abdominal aortic aneurysm <4cm
- Ascending aortic aneurysm. Please refer to Cardiology
- Uncomplicated varicose veins

CONDITIONS

ARTERIAL

- Aortic Aneurysm (also including visceral and peripheral)
- Renal Artery Stenosis and Mesenteric Angina
- Carotid Artery Disease
- Ischaemic Rest Pain, Ulcers and Gangrene
- Functional Ischaemia: Claudication
- Thoracic Outlet Syndrome
- Vasospastic Disease, Embolic/Occlusive Disease
- High-Risk Foot Ulcers
- Hyperhidrosis

VENOUS

Deep Vein Thrombosis

Varicose Veins

LYMPHATIC

Lymphoedema

ARTERIAL, VENOUS OR NEUROPATHIC ULCER

Non-Healing or Chronic Lower Leg Ulcers

Refer to Nephrology for the following:

- **Vascular Access Surgery including renal dialysis access or other long term vascular access**
- **Renal and Pancreas transplantation**

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: Mr Ming Yii

Program Director: Mr Alan Saunder

Last updated: 06/11/2023

Monash Health Referral Guidelines

(Incorporating Statewide Referral Criteria)

VASCULAR SURGERY

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 the on-call Vascular Surgery Registrar on 9594 6666

General enquiries

Phone: 1300 342 273

Head of unit:	Program Director:	Last updated:
Mr Ming Yii	Mr Alan Saunder	06/11/2023

ARTERIAL – AORTIC ANEURYSM

AORTIC ANEURYSM

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Abdominal aortic aneurysm > 4.0cm diameter measure
- Descending thoracic aortic aneurysm > 5.0cm diameter measure
- Rapid abdominal aortic aneurysm expansion (>1.0cm diameter growth per year)

Information to be included in Referral

Information that **must** be provided:

- Current and previous imaging results (Abdominal Ultrasound, if available CT Angiogram)
- Reason for referral – incidental or symptomatic
- Duration of symptoms
- Abdominal examination – most significant abdominal aortic aneurysms are palpable
- Management of atherosclerotic risks
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Family history

Investigations:

- FBC
- UEC
- Fasting lipids – HDL, LDL, TG
- Fasting or random glucose. If abnormal glucose include HbA1C

Additional Comments

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

The decision to refer should be based on diameter measurements, not the length of an aneurysm. Referrals for dilatation of the ascending aorta should be directed to a cardiology service provided by the health service

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

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Present or suspected acute aortic dissection
- Suspected ruptured abdominal aortic aneurysm or thoracic aortic aneurysm

Immediately contact the vascular registrar to arrange urgent vascular assessment for:

- Suspected intact symptomatic abdominal aortic aneurysm or thoracic aortic aneurysm

Urgent

Abdominal Aortic Aneurysm: Aneurysms 5.5cm or greater or tender aneurysms should be referred as urgent

Thoracic Aortic Aneurysm: Large secular aneurysm greater than 5cm

Routine

Abdominal Aortic Aneurysm:

- Greater than 4.0cm diameter
- Surveillance in consultation with General Practice

SEMPHN Pathways

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

Aortic Aneurysm pathway

HealthPathways

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

BACK

ARTERIAL – AORTIC ANEURYSM

AORTIC ANEURYSM (continued)

Referral to a public hospital is not appropriate for

- Incidental aortic aneurysm <4.0cm
- Ectatic aortic dilatation only
- Incidental visceral aneurysm < 1cm

Additional Information – Thoracic Aortic Aneurysm

Thoracic aortic aneurysm >5cm

- Routine chest x-ray and Chest and Abdominal CT angiogram
- Echocardiogram if available

Additional Information – Visceral Aneurysms

Visceral Aneurysms include Renal, Splenic, Mesenteric and Hepatic Aneurysms

- Size > 1cm refer for assessment
- Size < 1cm and incidental, monitor in general practice

BACK

ARTERIAL – RENAL ARTERY STENOSIS AND MESENTERIC ANGINA

RENAL ARTERY STENOSIS AND MESENTERIC ANGINA

Initial GP Work Up

- Presentation: Other atherosclerotic disease, severe hypertension, post-prandial pain, weight loss
- Standard history and examination

Referral **must** include clinical information

- Reason for referral – incidental or symptomatic
- Duration and timing of symptoms
- Management to date and response to treatment
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Family history

Investigations:

- FBE, ESR
- UEC
- Fasting or random glucose, if abnormal include HbA1C
- Imaging results – Vascular Doppler Ultrasound, if available CT Angiogram

Management Options for GP

- Best medical treatment for atherosclerotic risks in asymptomatic patient especially smoking and blood pressure
- Very limited role for intervention except in uncontrollable hypertension or fibromuscular dysplastic disease

Referral to a public hospital is not appropriate for

- Incidental renal artery stenosis
- Incidental mesenteric artery plaque
- Atherosclerotic stenosis < 50%

WHEN TO REFER?

Emergency

- Malignant hypertension to see cardiologist, vascular physician or renal physician
- Associated acute renal failure or cardiac failure

Urgent

- Uncontrolled hypertension – refer to Nephrology
- Significant weight loss with post-prandial pain

Routine

- Renal Artery Stenosis – after Nephrologist assessment
- Mesenteric Stenosis – if loss of weight > 5kg

BACK

ARTERIAL – CAROTID ARTERY DISEASE

CAROTID ARTERY DISEASE

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Internal carotid stenosis (> 50%) on imaging with symptoms (excluding dizziness alone), more than two weeks after onset of symptoms
- Asymptomatic internal carotid stenosis > 70% on imaging
- Carotid body tumour
- Symptomatic carotid related cerebral ischaemic symptoms, i.e. ipsilateral visual loss, contralateral facial or limb sensory or motor (weakness) disturbances

Information to be included in Referral

Information that **must** be provided:

- Symptoms
- Duration and timing of symptoms
- Current and previous imaging results
  - ECG if available
  - CT Angiogram if available
- Investigations:
  - FBC
  - UEC
  - Fasting lipids – HDL, LDL, TG
  - Fasting or random glucose, if abnormal include HbA1C
- Reason for referral – incidental or symptomatic (specific e.g. hemispheric symptoms, amaurosis fugax etc)
- Management to date and response to treatment
- Past medical history
- Current medications and medication history
- Usual functional status
- Psychosocial history
- Family history

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

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Transient ischaemic attack(s) in last 48 hours
- Multiple or recurrent transient ischaemic attack episodes in the last seven days
- Amaurosis fungax in last 48 hours
- Strokes

Immediately contact the vascular registrar to arrange an urgent vascular assessment for:

- Symptomatic internal carotid stenosis (> 50% on imaging), within two weeks of symptoms

Urgent

- Carotid bruit with hemispherical or ipsilateral eye recurrent symptoms
- Critical carotid stenosis (greater than 90% by ultrasound)
- Patient with Crescendo TIAs

Routine

Criteria for referral to public hospital specialist clinic services:

- Internal carotid stenosis (> 50% on imaging) with symptoms (excluding dizziness alone), more than two weeks after onset of symptoms
- Asymptomatic internal carotid stenosis > 70% on imaging
- Carotid body tumour
- Fibromuscular dysplastic disease

BACK

ARTERIAL – CAROTID ARTERY DISEASE

CAROTID ARTERY DISEASE (continued)

Referral to a public hospital is not appropriate for

- Asymptomatic internal carotid stenosis < 70% on imaging
- Isolated external carotid artery stenosis
- Dizziness alone or problem with balance or poor coordination – refer to Neurology service
- Non-specific bilateral blurred vision – refer to Ophthalmology service

Management Options for GP

- Commence aspirin
- Manage other risk factors

SEMPHN Pathways

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

Carotid artery stenosis pathway

HealthPathways

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

BACK

ARTERIAL – SEVERE LOWER LIMB ISCHAEMIA

ISCHAEMIC REST PAIN, ULCERS AND GANGRENE

Initial GP Work Up

- Presentation: Rest pain in the foot, nocturnal pain, skin necrosis, ulceration and gangrene
- Standard history and risk factors
- Peripheral pulses

Referral **must** include clinical information

- Reason for referral: pain, necrosis, ulcer or gangrene
- Duration of symptoms, pain history and location
- Current management to date and response to treatment including current podiatry treatment
- Past medical history including details on diabetes (e.g. year of onset, type) and smoking
- Current medications and medication history if relevant including antibiotics
- Functional status
- Psychosocial history
- Family history

Investigations:

- UEC, LFTs, FBE, CRP
- Fasting glucose and HbA1C
- Fasting cholesterol – HDL, LDL, TG
- Vascular imaging especially arterial Doppler ultrasound from the abdomen down the leg if pulses are not palpable
- Tissue sample/wound swab MC&S if suspicious of infection in ulcer or wounds

Management options for GP for stable diabetic foot ulcer

- Consider oral antibiotics only if cellulitic and highly suspicious of infection as per antibiotic guidelines
- Manage risk factors particularly smoking
- Complex medical history may benefit from vascular physician referral
- Commence aspirin and appropriate statins

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Systemic toxicity - sepsis or acutely unwell in association with infected necrosis, ulcer or gangrene
- Critical lower limb ischaemia with necrosis, pain or ulceration with diabetes
- Cellulitis: erythema, swelling and tender leg or foot
- Rapidly deteriorating deep ulceration or necrosis or purulent discharge
- Suspected foreign body in the foot

Urgent

- Symptoms > 4 weeks duration that are not improving despite best medical practice for atherosclerosis
- Ischaemic rest pain in the presence of diabetes
- Suspected osteomyelitis e.g. wound probing to bone or x-ray changes, or persistent soft tissue infection of the foot not responding to appropriately prescribed antibiotic therapy
- Critical ischaemia in the presence of significant renal disease

BACK

ARTERIAL - CLAUDICATION

FUNCTIONAL ISCHAEMIA: CLAUDICATION

Initial GP Work Up

- Severe claudication more or less than 100 meters and/or associated rest pain
- Active foot sepsis
- Worsening of ischaemic state or increasing pain

Referral **must** include clinical information

- Duration of symptoms, location, radiation and progression
- Current management to date and response to treatment
- Past medical history including details on diabetes (e.g. year of onset, type) and smoking
- Current medications and medication history if relevant including antibiotics
- Functional status
- Psychosocial history
- Family history

Investigations:

- UEC, LFTs, FBE
- Fasting glucose and HbA1C
- Fasting cholesterol – HDL, LDL, TG
- Vascular imaging especially arterial Doppler ultrasound from the abdomen down the leg

Referral to a public hospital is not appropriate for

- Claudication > 500m
- Asymptomatic arterial stenosis on imaging
- Isolated tibial artery stenosis or occlusion

Management options for GP for stable diabetic foot ulcer

- Manage risk factors particularly smoking
- Complex medical history may benefit from vascular physician referral
- Commence aspirin and appropriate statins
- Initiate walking program

WHEN TO REFER?

Urgent

Worsening of ischaemic state or increasing pain

BACK

ARTERIAL - OTHERS

THORACIC OUTLET SYNDROME

Initial GP Work Up

Presentation: Thoracic outlet syndrome

- Standard history to differentiate between neurogenic, artierial or venous aetiology
- Related to arterial and venous insufficiency in upper limb and neurological symptoms

Investigations:

- Rule out all other pathologies
- X-ray of cervical spine, chest x-ray and thoracic outlet

WHEN TO REFER?

Emergency

- Acute thrombosis of the subclavian or axillary vein with venous congestion
- Acute ischaemic upper limb from thromboembolism

Urgent

Mark referral urgent for neurological symptoms or prolonged arterial or venous insufficiency > 2 weeks

BACK

VASOSPASTIC DISEASE, EMBOLIC/OCCLUSIVE DISEASE

Initial GP Work Up

Presentation: Vasospastic disease

- Embolic/occlusive disease
- Blood pressure taken in both arms
- Degree of ischaemia
- Trophic changes
- Check for cardiac arrhythmia including
- AF
- Assess for connective tissue disorder

Investigations:

- Routine FBC
- HbA1C
- U&E, RBG, connective tissue disease screen

Management Options for GP

- Advice in regard to precipitants, eg cold exposure, machinery
- Avoid smoking
- Consider trial of medications such as Nifedipine

WHEN TO REFER?

Urgent

Critical ischaemia with rest pain or necrosis

Routine

- Connective tissue disorders when significant pain and/or disability not responding to conservative measures.
- Cases with trophic changes

BACK

ARTERIAL – DIABETIC FOOT/HIGH RISK FOOT CONDITIONS

HIGH-RISK FOOT ULCERS

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Non-healing foot ulceration present for more than one month with no reduction in size despite medical management
- Red hot swollen foot (active Charcot foot)
- Foot osteomyelitis with ulceration
- Chronic ischaemic signs and symptoms of the lower limb with foot ulceration
- Neuropathic symptoms associated with deranged function and structure
- Foot problems with underlying diabetes

Information to be included in Referral

Information that **must** be provided:

- Past medical history including history of diabetes (e.g. year of onset, type) and smoking
- Current medication list including any antibiotics
- Duration of symptoms, wound history and location
- Current management to date and response to treatment including current podiatry treatment
- Recent HbA1c and creatinine blood test
- Recent vascular imaging
- Reason for referral: complex non-healing foot ulceration with diabetes
- Current medications and medication history if relevant including antibiotics
- Functional status
- Psychosocial history
- Family history

Investigations:

- UEC, LFT's, FBE, CRP
- HbA1C
- Fasting glucose
- Fasting cholesterol – HDL, LDL, TG
- Urine ACR
- Plain x-ray or other vascular imaging
- Tissue sample/wound swab MC&S

Provide if available:

- Medical history
- Recent pathology tests including wound swabs
- X-rays or other imaging
- Current podiatry treatment

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Systemic toxicity - Sepsis or acutely unwell due to foot infection
- Critical lower limb ischaemia with necrosis, pain or ulceration
- Suspected acute limb ischaemia
- Cellulitis: erythema, swelling and tender foot
- Rapidly deteriorating deep ulceration or necrosis or purulent discharge
- Suspected foreign body in the foot

Urgent

- Foot ulcers > 4 weeks duration that are not improving despite best practice wound care and offloading
- Red hot swollen foot suspicious of active Charcot foot
- Foot ulcers in the presence of known or suspected Peripheral Arterial Occlusive Disease, i.e. no palpable pulses, short distant claudication or rest pain
- Suspected osteomyelitis e.g. wound probing to bone or x-ray changes, or persistent soft tissue infection of the foot not responding to appropriately prescribed antibiotic therapy
- Foot ulcers in the presence of significant renal disease

Routine

Neuropathic symptoms associated with deranged foot function and structure

BACK

ARTERIAL – DIABETIC FOOT / HIGH RISK FOOT CONDITIONS

HIGH-RISK FOOT ULCERS (Continued) → WHEN TO REFER?

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

Referrals should only be directed to a vascular specialist if a high-risk foot service is not available.

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
Not applicable

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

Leg ulcers pathway

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

Management Options for GP
- Consider referral to podiatrist for wound management and offloading if stable
- Consider arterial duplex ultrasound of lower limb if pedal pulses are not palpable
- Consider commencing oral antibiotics for infected ulcer according to Antibiotic guidelines

Additional Comments
Referrals may be directed to Monash Health high-risk foot service which provides a multidisciplinary approach to assist in the management of Diabetes related foot conditions.
Patients with diabetes-related foot conditions should also be referred to Endocrinology.

BACK

ARTERIAL - OTHERS

HYPERHIDROSIS

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

None, referrals for hyperhidrosis should not be made to this service

Information to be included in Referral

Not applicable

Additional Comments

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

Referrals for patients with hyperhidrosis should be directed to a dermatology 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

Not applicable

HealthPathways

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

Suggested GP Work Up for hyperhidrosis

- History of profound sweating of hands and axillae unresponsive to conservative treatment

Investigations:

- Thyroid function tests

Management Options for GP

- As appropriate and if uncontrollable, see Dermatologist

BACK

VENOUS – DEEP VEIN THROMBOSIS

DEEP VEIN THROMBOSIS

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Post thrombotic syndrome
- Symptomatic chronic iliofemoral venous obstruction
- Iliac vein compression syndrome (May-Thurner syndrome)
- Symptomatic acute or chronic venous thrombosis

Information to be included in Referral

Information that **must** be provided:

- History of deep vein thrombosis
- Symptoms
- History of previous surgery or trauma
- Current medication list
- Full medical history

Investigations:

- FBC
- UEC
- Fasting or random glucose, if abnormal HbA1C
- Fasting lipids – cholesterol, HDL, LDL, TG

Provide if available:

- Current and previous imaging results
- Thrombophilia testing:
  - Protein C, Protein S
  - Anti-thrombin III, Lupus serology, Rheumatoid factors
  - INR, APTT, LFT's

Additional Comments

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

Other types of deep vein thrombosis and patients with chronic venous insufficiency require medical rather than surgical management

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

Not applicable

(Continued over page)

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Present, or suspected, acute iliofemoral or supra-inguinal deep vein thrombosis
- Present or suspected acute axillary or subclavian vein thrombosis

Routine

- Post thrombotic syndrome
- Symptomatic chronic iliofemoral venous obstruction
- Iliac vein compression syndrome (May-Thurner syndrome)

BACK

VENOUS – DEEP VEIN THROMBOSIS

DEEP VEIN THROMBOSIS (Continued) WHEN TO REFER?

SEMPHN Pathways

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

Deep Vein Thrombosis pathway
Anticoagulation Therapy for DVT pathway

HealthPathways

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

Management Options for GP

- Graduated compression stocking if there is no arterial disease

BACK

VENOUS – VARICOSE VEINS

VARICOSE VEINS

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Symptomatic varicose vein with a CEAP* classification of C3, C4, C5 or C6. That is varicose veins with these clinical characteristics:
  - Oedema
  - Pigmentation, eczema, lipodermatoscerleosis, atrophie blanche
  - healed venous ulcer
  - active venous ulcer

Information to be included in Referral

Information that **must** be provided:

- Symptoms
- Description of oedema

Provide if available:

- Current and previous imaging results including venous incompetence Doppler ultrasound (not a venous thrombosis scan). If this has not been done, it is preferably done at Vascular Ultrasound Service (Dandenong), appointment via Tel: 9554 8022

Vascular Ultrasound Service Referral Form

Additional Comments

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

* CEAP classification: clinical findings, etiological factors, anatomical cause, pathophysiological cause

Note the indications for varicose vein procedures in the Elective Surgery Access Policy 2015:

Venous conditions with the following symptoms:

- Chronic leg swelling/oedema
- Chronic dermatitis/eczema
- Bleeding
- Leg ulcers or infections
- Superficial thrombophlebitis

Venous disorders in patients less than 16 years old

(Continued over page)

WHEN TO REFER?

Emergency

Immediately contact the vascular registrar to arrange an urgent vascular assessment for:

- Ascending thrombophlebitis within 7cm of the saphenofemoral junction
- Significant haemorrhage from varicose vein

Routine

- Symptomatic varicose vein with a CEAP* classification of C3, C4, C5 or C6. That is varicose veins with these clinical characteristics:
  - Oedema
  - Pigmentation, eczema, lipodermatoscerleosis, atrophie blanche
  - healed venous ulcer
  - active venous ulcer

* CEAP classification: clinical findings, etiological factors, anatomical cause, pathophysiological cause

BACK

VENOUS – VARICOSE VEINS

VARICOSE VEINS (Continued) WHEN TO REFER?

Excluded as indications for surgery are:
- Venous conditions which are unlikely to lead to the conditions listed above
- Cosmetic veins in patients greater than 16 years old
- Spider veins in patients greater than 16 years old

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
- Spider veins
- Varicose veins without symptoms or complications
- CEAP classification of C0, C1 or C2. That is varicose veins with these clinical characteristics:
  - no visible or palpable signs of venous disease
  - Telangiectasias or reticular veins
  - Varicose veins

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

Varicose Veins pathway

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

Management Options for GP
- Graduated compression stocking if normal pulses

BACK

LYMPHATIC

LYMPHOEDEMA

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Routine

Leg swelling

Criteria for Referral to Public Hospital Specialist Clinic Services

None

Information to be included in Referral

Not applicable

Additional Comments

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

Referrals should be directed to a multidisciplinary lymphoedema 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

Not applicable

SEMPHN Pathways

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

Lymphoedema pathway

HealthPathways

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

BACK

ARTERIAL, VENOUS OR NEUROPATHIC ULCER

NON-HEALING OR CHRONIC LOWER LEG ULCERS

DHHS Statewide referral criteria apply for this condition

Criteria for Referral to Public Hospital Specialist Clinic Services

- Non-healing ulceration present for more than one month with no reduction in size despite medical management
- Chronic ischaemic signs and symptoms with ulceration
- Excessively painful ulcers
- Chronic venous disease
- Non-healing painless ulcers

Information to be included in Referral

Information that **must** be provided:

- Current medication list including any antibiotics
- Wound history and location
- Current management, including the dressings being used
- Recent wound swabs
- Recent vascular imaging

Provide if available:

- Medical history
- Recent pathology tests
- X-rays or other imaging (relevant arterial or venous Doppler ultrasound)
- Current podiatry treatment

Additional Comments

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

Referrals should only be directed to a vascular specialist clinic if a lower leg ulcer service is not available
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

Not applicable

SEMPHN Pathways

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

Leg ulcers pathway

HealthPathways

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

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Sepsis or acutely unwell due to infection
- Critical lower limb ischaemia with necrosis, pain or ulceration
- Suspected acute limb ischaemia
- Rapidly deteriorating ulceration or necrosis

Routine

Leg swelling, pigmentation, venous ulcers, bleeding

BACK