Monash Health Referral Guidelines
HAEMATOLOGY

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

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Last updated: 05/12/2023

Monash Health Referral Guidelines
HAEMATOLOGY

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

ACUTE AND CHRONIC LEUKAEMIA

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

BACK

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 10^9/L

Urgent

- Patients with thrombocytopenia with a count less than 50 x 10^9/L
- More than one abnormal result (eg neutropenia associated with anaemia and/or thrombocytopenia)

Routine

Most cases of anaemia with no other complications

BACK

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**

BACK

PARAPROTEINEMIA AND MULTIPLE MYELOMA

PARAPROTEIN AND MULTIPE 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

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

Acute proximal deep vein thrombosis

Acute pulmonary embolism

Routine

Assessment required prior to planned surgery or pregnancy

BACK

GENERAL

GENERAL

Initial GP Work Up

Full Blood Examination / Film

Management Options for GP

N/A

WHEN TO REFER?

Routine

Likely routine unless otherwise indicated from pathology results

BACK

IRON OVERLOAD

IRON OVERLOAD → **WHEN TO REFER?**

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

Routine

Most referrals considered routine

BACK

IRON DEFICIENCY

IRON DEFICIENCY → **WHEN TO REFER?**

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)

Routine

- Anaemia refractory to iron and B12/folate
- Persistent unexplained anaemia

BACK

POLYCYTHEMIA

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

BACK

THROMBOCYTOSIS & LYMPHOCYTOSIS

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 >450 x10^9/L and:
  - Neurological symptoms
  - Abnormal bleeding
  - Recent thrombotic event

Routine

Refer to haematology if cause of thrombocytosis or lymphocytosis not identified

BACK