

Monash Health Referral Guidelines

CLINICAL NUTRITION

EXCLUSIONS

Services not offered by Monash Health

Psychiatric management of eating disorders – consider referring to [Eating Disorders Unit](#)

Full diagnostic process to identify causes of malabsorption – consider referral to [Gastroenterology Outpatients](#)

Patients under 18: Click here for Monash Children's [General Paediatric guidelines](#)

CONDITIONS

[Home enteral or parenteral nutrition](#)

[Intestinal failure](#)

[Lipid disorders](#)

[Malabsorption/malnutrition](#)

[Low bone density](#)

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

Last updated:

November 2024

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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 Clinical Nutrition Registrar on 9594 6666 (office hours only)

General enquiries

Phone: 1300 342 273

HOME ENTERAL/PARENTERAL NUTRITION/INTESTINAL FAILURE

HOME ENTERAL/PARENTERAL NUTRITION/ INTESTINAL FAILURE



WHEN TO REFER?

Patient Presentation

- Patient may have been discharged from hospital with nutrition support (enteral/parenteral)
- Patient may have an inability to consume and/or absorb sufficient energy, protein and/or micronutrients from diet

Initial GP Work Up

- Height, weight (premorbid and current)
- Biochemical measures of nutritional status (the following may be appropriate):
 - FBE, UEC, CMP
 - LFT, transthyretin
 - TFT, PTH
 - Fasting lipids
 - Fasting glucose, HbA1C
 - Fe studies, B12, folate
 - Vit D
- Document cause of intestinal failure if known

Management Options for GP

- Replace micronutrient deficiencies as identified
- Referral to community dietitian if appropriate

Urgent

- If patient requires continuing support with existing nutrition supplementation
- If objective measures of malnutrition (documented inadequate intake, weight loss, biochemical abnormalities) persist despite initial management in patients previously not receiving nutrition support

Routine

- All patients on home parenteral nutrition and/or intestinal failure require specialist assessment and management
- Monash has a dedicated Clinical Nutrition Clinic offering the above services

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LIPID DISORDERS

Patient Presentation

- Inherited lipid disorders with severe dyslipidaemia.
Approximate guide: Total Cholesterol >7mmol/L,
Triglycerides ≥6mmol/L
- Patients with hypertriglyceridaemia and pancreatitis

Initial GP Work Up

- Total Cholesterol, HDL, LDL, Triglyceride Level and trend over time
- TFT, LFT, UEC
- Screening for diabetes or evidence of poor diabetes control
- Results of any other cardiovascular investigations

Management Options for GP

- Standard PBS therapies

WHEN TO REFER?

Emergency

Patients with symptoms of acute pancreatitis should present to the emergency department

Routine

Patients intolerant, contraindicated to, or with refractory profiles to standard lipid lowering therapies

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MALABSORPTION/MALNUTRITION

MALABSORPTION/MALNUTRITION

WHEN TO REFER?

Patient Presentation

- Associated with chronic disease
 - Eg. Coeliac disease
 - Pancreatic insufficiency
 - Post-surgical
 - Cholestasis/chronic liver disease
 - Inflammatory bowel disease
 - Radiation enteropathy
 - Dietary intolerances
- Steatorrhoea
- High faecal output
- Weight loss
- Clinical or laboratory evidence of vitamin or mineral deficiency
- Underweight by BMI (<18.5 kg/m²)

Initial GP Work Up

- Height, weight (premorbid and current)
- Biochemical measures of nutritional status (the following may be appropriate):
 - FBE, UEC, CMP
 - LFT, transthyretin
 - TFT, PTH
 - Fasting lipids
 - Fasting glucose, HbA1C
 - Fe studies, B12, folate
 - Vit D

Management Options for GP

- Replace micronutrient deficiencies as identified
- Referral to community dietitian if appropriate
- Referral to psychiatrist/psychologist if indicated

Urgent

If objective measures of malnutrition (documented inadequate intake, weight loss, biochemical abnormalities) persist despite initial management

Routine

Monash has a dedicated Clinical Nutrition Clinic offering specialist assessment and management of malabsorption/malnutrition.

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LOW BONE DENSITY

LOW BONE DENSITY

WHEN TO REFER?

Patient Presentation

Low bone density reported on bone densitometry scan (DXA) with T score less than minus 2.0

Initial GP Work Up

- FBE, UEC, CMP, LFT
- 25 hydroxy vitamin D level
- TFT, PTH
- Fe studies, celiac serology
- FSH, LH (for women)
- Testosterone (for men)
- P1NP, CTX (if already on anti-resorptive therapy)
- Plain thoraco-lumbar spine XRAY with PA and lateral views

Management Options for GP

- Correct Vitamin D deficiency
- Ensure adequate calcium intake
- Assess and manage falls risk
- Ensure no significant dental issues

Routine

- Patients with low bone density who do not qualify for PBS subsidised anti-resorptive therapy
- Low bone density in the setting of short bowel syndrome or other malabsorption disorders
- Low bone density in the setting of eating disorders (e.g. anorexia nervosa)

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