

# 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 \(Rheumatology\)](#)

#### MUSCULOSKELETAL 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

Last updated:  
November 2024

# Monash Health Referral Guidelines

Incorporating Statewide Referral Criteria

## Rheumatology

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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](#).

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### 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)

## WHEN TO REFER?

[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

### 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.

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## INFLAMMATORY ARTHRITIS

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### 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).

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# INFLAMMATORY ARTHRITIS

## ANKYLOSING SPONDYLITIS (INFLAMMATORY BACK PAIN)

## WHEN TO REFER?

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.

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### 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

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## INFLAMMATORY ARTHRITIS

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### 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).

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# INFLAMMATORY ARTHRITIS

## INFLAMMATORY ARTHRITIS (Rheumatoid arthritis and suspected inflammatory arthritis)

## WHEN TO REFER?

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.

### 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).

# INFLAMMATORY ARTHRITIS

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

## WHEN TO REFER?

### 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<sup>2</sup>
  - 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.

### 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).

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# 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

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## 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

#### 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

#### 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

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## 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. Spondyloarthritis

#### 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 inflammatory 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 Neurosurgical registrar for advice

#### Urgent

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

#### Routine

- Most cases of mechanical/degenerative back pain do not require specialist input and these referrals will be rejected.
- 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)

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## 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

- Most cases of soft tissue rheumatism can be managed in the community and referral is not required.
- Consider local injection therapy including imaging-guided if needed
- Consider NSAID if not contraindicated
- Physiotherapy is of value especially ROM and strengthening exercises
- Shoulder US usually shows cuff degeneration in older people



### WHEN TO REFER?

#### Routine

- Cases refractory to NSAIDs, steroid injection and physiotherapy can be referred, although it should be noted that management options beyond these approaches are limited
- Cases with diagnostic uncertainty can be referred.



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### OSTEOARTHRITIS

- Chronic joint pain
- Lack of inflammatory features

#### Initial GP Work Up

- Establish diagnosis
- Exclude inflammatory disease: CRP

#### Management Options for GP

- Patient education (Arthritis Foundation)
- Physical therapy, hand therapy
- Self management skills
- Orthotic assessment
- Simple analgesia

### WHEN TO REFER?

#### 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

## NON-INFLAMMATORY BONE AND JOINT DISEASE

### METABOLIC BONE DISEASE

Please note metabolic bone disease and osteoporosis clinics are managed by the endocrinology unit at Monash Health. Please refer to Endocrinology referral guidelines.

DHHS [Statewide referral criteria](#) apply for this condition



### WHEN TO REFER?

#### 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 – these are run by the Endocrinology Unit. Please refer to Endocrinology referral guidelines

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# MUSCULOSKELETAL PAIN SYNDROMES

## FIBROMYALGIA AND COMPLEX REGIONAL PAIN SYNDROMES

## WHEN TO REFER?

### 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 in a gentle, graded manner
- Emphasis on self management
- Involve multidisciplinary approach e.g. pain management CBT via clinical psychologist
- Low dose tricyclic antidepressants / pregabalin/simple analgesia
- Avoid narcotic analgesia

### 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

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