Monash Health Referral Guidelines Interventional Radiology

EXCLUSIONS

Services not offered by Monash Health

For patients requiring **diagnostic imaging only**, or those requiring **minor procedures** with no clinical management by interventional radiology e.g. biopsy, PICC line, ascitic/pleural tap etc... – please use the standard **Monash Imaging Request Form**

CONDITIONS

- Arterial and venous conditions requiring endovascular treatment
- Vascular malformations in adults and children
- · Percutaneous ablation of soft tissue, visceral and bone tumours
- Embolisation of urogynaecological conditions (e.g. BPH, fibroids, adenomyosis)

See subsequent pages for more detailed condition information

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

REFERRAL

How to refer to Monash Health

Mandatory referral content

Demographic:

Full name

Date of birth

Next of kin

Postal address

Contact number(s)

Email address

Medicare number

Referring GP details

including provider number

Usual GP (if different)

Interpreter requirements

Clinical:

Reason for referral

Duration of symptoms

Management to date and response to

treatment

Past medical history

Current medications and medication

history if relevant

Family history

Diagnostics as per referral guidelines



Click here to download the outpatient referral form

Head of unit:

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Last updated:

July 2025



Monash Health Referral Guidelines Interventional Radiology

CONTACT US

Medical practitioners

Non-urgent enquiries:

Interventional Radiology Bookings Office (MMC) (03) 9594 2179

Clinically urgent enquiries:

On-call Interventional Radiology Fellow via Monash Switchboard (03) 9594 6666

General enquiries

Phone: 1300 342 273

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ARTERIAL CONDITIONS

Congenital or acquired Vascular Malformations (adult or paediatric)

These patients will be managed collaboratively as part of the Monash and Monash Children's Vascular Malformation Multi-disciplinary Service

Initial Work Up

- Standard History and Examination
- · Doppler Ultrasound of lesion
- · Serology FBE, UEC and Coags

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Acute bleeding; Rapid increase in size; Compression of adjacent structures e.g. airway; Neurological symptoms

Urgent

Pain or symptoms affecting activities of daily living, employment, study, childhood development

Routine

All non-emergency, non-urgent presentations

BACK

Arterial or visceral organ aneurysms (e.g. hepatic, renal, splenic, pulmonary etc...).

These patients will be managed collaboratively with the appropriate Monash Health Surgical Service and concurrent referrals will be made.

Initial Work Up

- Standard history and examination
- Cross-sectional imaging of lesion (CT or MRI)
- · Serology FBE, UEC, LFTs, Coags

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Acute bleeding; End organ dysfunction; Severe pain

Urgent

Increasing size on serial imaging; Size greater than 20mm; Pregnant or woman of childbearing age

Routine

All non-emergency, non-urgent presentations

BACK

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Peripheral Arterial Vascular Disease e.g. lower/upper limb arterial stenosis or occlusion, claudication etc...

These referrals will be re-directed to the Monash Vascular Surgery clinic if not yet seen by a Monash Vascular Surgeon. Only referrals from Monash Health Vascular Surgery Consultants will be accepted.

Initial Work Up

- · Standard history and examination
- Arterial Doppler Ultrasound or CTA of the limb
- Serology FBE, UEC, Coag

Initial Management Options

· Consider smoking history and cessation

WHEN TO REFER?

Emergency

Pain at rest; Acute pain, swelling, skin changes or neurological symptoms

Urgent

Chronic skin changes; Venous ulcers; Chronic bleeding,

Routine

All non-emergency, non-urgent presentations

BACK

Head of unit:A/Prof Diederick De Boo

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VENOUS CONDITIONS

Renal vascular access (e.g. AV fistula intervention, Permacath for dialysis)

Referrals from outside Monash health will be redirected to the Renal Access Outpatient Service.

Only secondary referrals from Monash Health Renal Access Consultants will be accepted.

Initial Work Up

- · Standard History and Examination
- Referral to Consultant Nephrologist for management of chronic renal failure/dialysis if not already done.

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Chronic renal failure requiring dialysis

Urgent

Threatened fistula with critical stenosis and/or low flow

Routine

All non-emergency, non-urgent presentations

BACK

Lower limb varicose veins

If not already seen by a Monash Health Vascular Surgeon these patients may be concurrently referred to the Vascular Outpatient Clinic and discussed with Monash Vascular Surgery for consideration of both surgical and endovascular treatment.

Initial Work Up

- Standard history and examination
- Venous Doppler Ultrasound preferably performed at the Monash Health Vascular Imaging Lab.
- · Serology FBE, UEC, Coags

Initial Management Options

· Compression stockings

WHEN TO REFER?

Emergency

Acute pain; Severe swelling; Acute skin changes; Signs of venous ischaemia; Acute bleeding

Urgent

Chronic skin changes; Venous ulcers; Chronic bleeding,

Routine

All non-emergency, non-urgent presentations

BACK

Head of unit:A/Prof Diederick De Boo

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Venous insufficiency e.g. (pelvic venous congestion, vulval, perineal or rectal varices, varicocele)

Initial Work Up

- Standard history and examination
- Venous Doppler Ultrasound preferably performed at the Monash Health Vascular Imaging Lab
- · Serology FBE, UEC, Coags

Initial Management Options

N/A

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WHEN TO REFER?

Emergency

Acute pain; Severe swelling; Acute skin changes; Signs of venous ischaemia; Acute bleeding

Urgent

Chronic skin changes; Venous ulcers; Chronic bleeding

Routine

Infertility (male patients with varicocele)

BACK

Acute or Chronic Deep Venous Thrombosis; May-Thurner Syndrome; Venous Thrombosis due to mechanical obstruction

If not already seen by a Monash Haematologist these referrals may be managed in conjunction with the Monash Haematology Service

Initial Work Up

- Standard history and examination
- · Venous Doppler Ultrasound
- CT imaging (optional)
- Serology FBE, UEC, Coags
- Unprovoked DVT antib2glycoprotein IgG and anticardiolipin IgG.

Initial Management Options

 Consideration of anticoagulation in conjunction with haematology guidelines or Specialist Haematologist

WHEN TO REFER?

Emergency

Acute pain; Severe swelling; Acute skin changes; Signs of venous ischaemia; Large volume thrombus e.g. Iliofemoral DVT, IVC involvement

Urgent

Chronic DVT affecting activities of daily living

Routine

Symptoms of post-thrombotic syndrome (after previous DVT)

BACK



ONCOLOGY CONDITIONS

Solid organ tumours (primary or metastatic) for consideration of thermal or chemical ablation e.g. Liver, Kidney, Lung, Soft Tissue, Bone

If not already done, these referrals will be discussed at the appropriate Oncology Multidisciplinary Team Meeting and managed in conjunction with Monash Health Oncology Services

Initial Work Up

- · Standard history and examination
- Cross-sectional imaging
- Serology FBE, UEC, Coags
- Tumour marker results (if available)
- Any external biopsy or histology results (if available)

Initial Management Options

- If not yet referred, consider concurrent referral to a Medical Oncologist.
- · Appropriate oncological staging

WHEN TO REFER?

Emergency

Acute bleeding; End-organ dysfunction; Neurological symptoms

Urgent

First diagnosis of cancer; No MDT discussion/plan

Routine

All non-emergency, non-urgent presentations

BACK

Liver cancer (HCC) or Liver metastases for consideration of trans-arterial chemoembolization, thermal or chemical ablation or Selective Internal Radiation Treatment (SIRT)

If not already done these patients will be discussed at the Monash Liver Mass/Hepatobiliary Oncology Multidisciplinary Team Meeting for consensus management.

Initial Work Up

- Standard history and examination
- Cross-sectional imaging (multiphase CT or MRI)
- Serology FBE, LFTs, UEC, Coags
- Tumour marker results e.g. AFP, Ca19-9 (if available)

Initial Management Options

- · Referral to Gastroenterologist
- Appropriate oncological staging

WHEN TO REFER?

Emergency

Acute abdominal pain; Jaundice; Portal vein thrombosis; Decompensated liver failure

Urgent

First diagnosis of liver tumour; Tumour size greater than 2cm;

Routine

All non-emergency, non-urgent presentations

BACK



Metastatic disease for consideration of thermal ablation or embolization

If not already done, these referrals will be discussed at the appropriate Oncology Multidisciplinary Team Meeting and managed in conjunction with Monash Health Oncology Services

Initial Work Up

- Standard history and examination
- Appropriate staging imaging
- Serology FBE, UEC, Coags

Initial Management Options

Consider referral to Specialist Oncologist if not already done.

WHEN TO REFER?

Emergency

Acute bleeding; Compression of adjacent structures causing neurological compromise (e.g. spine) or pathological fracture

Urgent

Impending compression of adjacent critical structures; Non-responsive to loco-regional therapy

Routine

All non-emergency, non-urgent presentations

BACK

Malignant venous obstruction (e.g. IVC or SVC obstruction)

Initial Work Up

- · Standard history and examination
- Contrast CT or MRI imaging (Venogram)
- · Venous doppler ultrasound
- Serology FBE, UEC, Coags

Initial Management Options

- Venous doppler ultrasound to rule out DVT
- In setting of co-existent DVT anticoagulation may be appropriate – discuss with Haematologist

WHEN TO REFER?

Emergency

Complete IVC or SVC obstruction with venous congestion

Urgent

Symptomatic moderate to severe iliofemoral, IVC or SVC obstruction

Routine

All non-emergency, non-urgent presentations

BACK

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GASTROINTESTINAL CONDITIONS

Recurrent GI bleeding (Haematemesis or Malena) in the setting of liver failure/cirrhosis for treatment of portal hypertension (e.g. TIPS, splenic embolisation etc...)

Initial Work Up

- · Standard history and examination
- · CT imaging of the abdomen
- Serology FBE, LFTs, UEC

Initial Management Options

 If not already referred, consider concurrent referral to a Gastroenterologist specialising in Hepatology/Cirrhosis.

WHEN TO REFER?

Emergency

Acute bleeding; Haemodynamic instability

Urgent

Recurrent bleeding causing Hb drop

Routine

All non-emergency, non-urgent presentations

BACK

Recurrent ascites in the setting of liver failure/cirrhosis for treatment of portal hypertension (e.g. TIPS)

Initial Work Up

- · Standard history and examination
- CT imaging of the abdomen
- · Serology FBE, LFTs, UEC

Initial Management Options

 If not already referred, consider concurrent referral to a Gastroenterologist specialising in Hepatology/Cirrhosis.

WHEN TO REFER?

Emergency

Large volume ascites with pain; Suspicion of infectious peritonitis

Urgent

Symptoms affecting activities of daily living

Routine

All non-emergency, non-urgent presentations

BACK

Head of unit:

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Biliary obstruction or jaundice requiring percutaneous transhepatic biliary procedures (PTC),
Biliary stone disease in patients not fit for surgical cholecystectomy.

These referrals will be managed in collaboration with the Monash Health Gastroenterology and/or Upper GI Surgery Services

Initial Work Up

- · Standard history and examination
- · Liver ultrasound
- Cross sectional imaging of the liver and biliary tree (if available)
- Serology FBE, UEC, LFTs, Coags

Initial Management Options

 If not already done, consider concurrent referral to an Upper GI Surgeon

WHEN TO REFER?

Emergency

Acute jaundice; Jaundice with pain and signs of infection e.g. raised inflammatory markers; Decompensated liver failure

Urgent

New symptoms of jaundice; Clinical suspicion of underlying malignancy

Routine

All non-emergency, non-urgent presentations

BACK

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THORACIC/RESPIRATORY CONDITIONS

Chronic haemoptysis

If not currently managed by a Monash Health Respiratory Physician these patients may be concurrently referred for collaborative management to the Monash Health Respiratory service.

Initial Work Up

- · Standard history and examination
- · Contrast CT of the chest (CTA Chest)
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

 If not already done, consider concurrent referral to a Respiratory Physician

WHEN TO REFER?

Emergency

Massive haemoptysis (volume greater than 600ml in 24 hours or 150ml in 1 hour); Haemodynamic instability; Risk to airway

Urgent

Persistent recurrent haemoptysis; Evidence of aspiration

Routine

All non-emergency, non-urgent presentations

BACK

Lung tumours primary or metastatic for consideration of percutaneous thermal ablation (e.g. microwave or cryoablation)

These patients will be managed in collaboration with the Monash Health Respiratory/Oncology and Thoracic Surgery Teams

Initial Work Up

- · Standard history and examination
- CT imaging of the chest
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

- If not already done, consider concurrent referral to a Respiratory Physician
- Appropriate oncological staging and consideration of biopsy for tissue diagnosis

WHEN TO REFER?

Emergency

Acute bleeding or haemoptysis; Lung collapse; Compression of mediastinal structures

Urgent

First diagnosis of cancer

Routine

All non-emergency, non-urgent presentations

BACK

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Pulmonary arteriovenous malformations

These patients will be managed in collaboration with the Monash Health Respiratory Team and if appropriate the Monash Clinical Genetics Service e.g. Hereditary Haemorrhagic Telangiectasia (HHT)

Initial Work Up

- · Standard history and examination
- Family history
- Contrast CT imaging of the chest (CTA)
- Transthoracic contrast echocardiography "echo bubble study"
- Serology FBE, LFTs, UEC, Coags

Initial Management Option

 Consider referral to Monash Clinical Genetics Service for testing and family counselling

WHEN TO REFER?

Emergency

Acute bleeding; Respiratory or Cardiovascular compromise; Neurological symptoms

Urgent

Pulmonary AVMs with feeding artery diameter greater than 3mm

Routine

All non-emergency, non-urgent presentations

BACK

Chronic pulmonary hypertension for consideration of catheter directed therapy

These patients will be managed collaboratively with the Monash Health Department of Cardiology and/or Cardiac Surgery

Initial Work Up

- · Standard history and examination
- CT Pulmonary Angiogram
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

 Consider concurrent referral to Respiratory and Cardiology.

WHEN TO REFER?

Emergency

Acute pulmonary embolus

Urgent

Signs of right heart failure

Routine

All non-emergency, non-urgent presentations

BACK

Head of unit:A/Prof Diederick De Boo

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MUSCULOSKELETAL AND CHRONIC PAIN CONDITIONS

Bone tumours (adult or children) for consideration of biopsy or thermal ablation

If not already done these patients will be referred to the Monash Health Orthopaedics Service (Adult or Paediatric) for collaborative management

Initial Work Up

- · Standard history and examination
- Y-Ray
- · Serology FBE, LFTs, UEC, Coags

Initial Management Options

- Referral to specialist Orthopaedic Oncology Service
- · Appropriate oncological staging
- Discussion at appropriate MDT

WHEN TO REFER?

Emergency

Pathological fracture; Compression of adjacent structures; Neurological symptoms

Urgent

Clinical suspicion of underlying malignancy

Routine

All non-emergency, non-urgent presentations

BACK

Image guided neurolysis (e.g. coeliac, ganglion impar blockade or ablation)

If not already done these patients may be referred to the Monash Health Pain Service for collaborative management.

Initial Work Up

- · Standard history and examination
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

 Suggest concurrent referral to Pain Physician for optimisation of oral analgesic regime

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WHEN TO REFER?

Emergency

Neurological symptoms

Urgent

Pain poorly controlled with medical therapy

Routine

All non-emergency, non-urgent presentations

BACK

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UROLOGICAL CONDITIONS

Symptomatic benign prostatic hypertrophy (BPH)

If not already seen by a Monash Health Urologist these patients may be referred to the Monash Health Urology Service for collaborative management.

Initial Work Up

- · Standard history and examination
- · Renal tract ultrasound
- Serology FBE, LFTs, UEC, Coags, PSA

Initial Management Options

Consider referral to Urologist for optimisation of medical management of BPH

WHEN TO REFER?

Emergency

Acute urinary obstruction

Urgent

Insert relevant information or delete text box if not appropriate

Routine

All non-emergency, non-urgent presentations

BACK

Hydronephrosis for elective nephrostomy or ureteric stent insertion

If not already seen by a Monash Health Urologist these patients may be referred to the Monash Health Urology Service for collaborative management.

Initial Work Up

- · Standard history and examination
- Renal tract ultrasound
- CT imaging of the abdomen
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Hydronephrosis with clinical features of sepsis

Urgent

Prior to a related surgical procedure e.g. access prior to percutaneous nephrolithotomy

Routine

All non-emergency, non-urgent presentations

BACK

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Last updated:



Renal cancer for consideration of image-guided percutaneous thermal ablation (RF, microwave or cryoablation)

These patients will be managed in collaboration with the Monash Health Department of Urology.

If not already seen by a Monash Health Urologist concurrent referrals will be made and the patient discussed at the Monash Urological Oncology Multidisciplinary Team Meeting.

Initial Work Up

- Standard history and examination
- Multiphase CT or MRI imaging of the kidney
- Staging CT
- Serology FBE, LFTs, UEC, Coags

Initial Management Options

- · Appropriate oncological staging
- · Consideration of tissue biopsy
- Discussion at appropriate MDT

WHEN TO REFER?

Emergency

Bleeding; Obstruction of the collecting system

Urgent

First diagnosis of cancer; Local invasion into vascular structures

Routine

All non-emergency, non-urgent presentations

BACK



GYNAECOLOGICAL CONDITIONS

Symptomatic uterine fibroids

If the patient has not been seen by a Monash Health Obstetrician/Gynaecologist a concurrent referral may be made to the Monash Obstetric/Gynaecology Service for collaborative management

Initial Work Up

- Standard history and examination
- Pelvic ultrasound (preferably via the Monash Women's Health Service)
- Serology FBE, UEC, Coags

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Acute intramural haemorrhage or worsening pain;

Urgent

Rapid growth, severe menstrual symptoms affecting quality of life

Routine

All non-emergency, non-urgent presentations

BACK

Uterine arteriovenous malformation with chronic bleeding

If the patient has not been seen by a Monash Health Obstetrician/Gynaecologist a concurrent referral may be made to the Monash Obstetric/Gynaecology Service for collaborative management

Initial Work Up

- · Standard history and examination
- Pelvic ultrasound (preferably via the Monash Women's Health Service)
- CT imaging
- Serology FBE, UEC, Coags, Group and Hold

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Acute PV bleeding; Haemodynamic instability

Urgent

Recurrent per vaginal bleeding

Routine

All non-emergency, non-urgent presentations

BACK

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Fallopian tube recanalization procedures

If the patient has not been seen by a Monash Health Obstetrician/Gynaecologist a concurrent referral may be made to the Monash Obstetric/Gynaecology Service for collaborative management

Initial Work Up

- · Standard history and examination
- Pelvic ultrasound (preferably via the Monash Women's Health Service)
- Serology FBE, UEC, Coags

Initial Management Options

N/A

WHEN TO REFER?

Emergency

Urgent

Routine

All non-emergency, non-urgent presentations

BACK

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Pelvic venous congestion, vulval, perineal or rectal varices

Initial Work Up

- Standard history and examination
- Venous Doppler Ultrasound preferably performed at the Monash Health Vascular Imaging Lab
- · Pelvic US or CT imaging of the pelvis
- Serology FBE, UEC, Coags

Initial Management Options

• N/A

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WHEN TO REFER?

Emergency

Acute pain; Severe swelling; Acute skin changes; Signs of venous ischaemia; Acute bleeding

Urgent

Chronic skin changes; Venous ulcers; Chronic bleeding

Routine

Infertility (male patients with varicocele)

BACK

Acute or Chronic Deep Venous Thrombosis; May-Thurner Syndrome; Venous Thrombosis due to mechanical obstruction

If not already seen by a Monash Haematologist these referrals may be managed in conjunction with the Monash Haematology Service

Initial Work Up

- Standard history and examination
- · Venous Doppler Ultrasound
- CT imaging (with contrast)
- Serology FBE, UEC, Coags

Initial Management Options

 Consideration of anticoagulation in conjunction with haematology guidelines or Specialist Haematologist

WHEN TO REFER?

Emergency

Acute pain; Severe swelling; Acute skin changes; Signs of venous ischaemia; Large volume thrombus e.g. Iliofemoral DVT, IVC involvement

Urgent

Chronic DVT affecting activities of daily living

Routine

Symptoms of post-thrombotic syndrome (after previous DVT)

BACK

