

# 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:

A/Prof Diederick De Boo

Program Director:

A/Prof. Ronnie Ptasznik

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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July 2025

## 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

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### 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

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

**WHEN TO REFER?**

*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

**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

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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

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### 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

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



**WHEN TO REFER?**

**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

**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)

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



**WHEN TO REFER?**

*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 - antiβ2glycoprotein IgG and anticardiolipin IgG.

**Initial Management Options**

- Consideration of anticoagulation in conjunction with haematology guidelines or Specialist Haematologist

**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)

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## 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

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### 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

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Last updated:

July 2025

## 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

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## 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

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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

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**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

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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

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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

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### 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

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## Pulmonary arteriovenous malformations



### WHEN TO REFER?

*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

#### 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

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## Chronic pulmonary hypertension for consideration of catheter directed therapy



### WHEN TO REFER?

*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.

#### Emergency

Acute pulmonary embolus

#### Urgent

Signs of right heart failure

#### Routine

All non-emergency, non-urgent presentations

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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
- X-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

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### 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

### WHEN TO REFER?

#### Emergency

Neurological symptoms

#### Urgent

Pain poorly controlled with medical therapy

#### Routine

All non-emergency, non-urgent presentations

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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

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### 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

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Last updated:

July 2025

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## 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 Multi-disciplinary 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

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## 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

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### 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

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## Fallopian tube recanalization procedures



## WHEN TO REFER?

*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

**Emergency**

**Urgent**

**Routine**

All non-emergency, non-urgent presentations

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## Pelvic venous congestion, vulval, perineal or rectal varices

### WHEN TO REFER?

#### 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

#### 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)

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

### WHEN TO REFER?

*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

#### 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)

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