Monash Health Referral Guidelines
RESPIRATORY & SLEEP

EXCLUSIONS

Services not offered by Monash Health

Patients under 18 years of age: Click here for Monash Children's Respiratory and Sleep Medicine guidelines.

There is no Long Covid Clinic or Chronic Fatigue Syndrome Clinic.

Undifferentiated chronic cough: Click here for more information.

CONDITIONS

AIRWAY DISEASE
- Bronchiectasis
- Asthma
- Chronic Obstructive Pulmonary Disease

PARENCHYMAL - LUNG DISEASE
- Pulmonary Fibrosis
- Sarcoidosis
- Other Intestinal Lung Disease (see Pulmonary Fibrosis)

INFECTION - LUNG
- Upper Respiratory Tract Infection
- Pneumonia / Lower Respiratory Tract Infection

PLEURAL
- Pleural Effusion
- Pneumothorax
- Pleural Plaques

NEOPLASIA - LUNG
- Mesothelioma
- Lung Cancer
- Lung Nodules

SLEEP DISORDERS
- Obstructive Sleep Apnoea
- Parasomnias
- Narcolepsy
- Insomnia
- Circadian and Shift-Work Disorder

CHRONIC COUGH
- Undifferentiated Chronic Cough

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:
29/08/2025

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RESPIRATORY & SLEEP

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 the Monash Health switchboard on: 9594 6666

General enquiries

Phone: 1300 342 273

Last Updated:
29/08/2025

AIRWAY DISEASE

BRONCHIECTASIS

Initial GP Work Up

Patient history:

- Should be considered in anyone with chronic or recurrent purulent sputum. Quantitate phlegm production when well and when ill.
- Past history of severe respiratory infection usually in childhood e.g. Whooping Cough.
- History of Asthma

Investigations:

- Spirometry with reversibility
- Chest X-ray
- HRCT Lungs, but not during an exacerbation
- FBC, ESR
- Sputum culture when patient otherwise well and with exacerbations
- Assess for sinus disease

Management Options for GP

- Maintenance treatment: sputum clearance techniques are the cornerstone of long term management (to be referred to physiotherapist for education but not before CT scan).
- Long term antibiotics in consultation with Respiratory Physician.
- Fluvax and Pneumovax.
- RSV vaccine
- Treatment of non-infective airways disease i.e. co-existing COPD and asthma should be considered. See below.
- Management of acute infective exacerbations e.g. acute bronchitis, pneumonia.
- Management in the community: antibiotics preferably post sputum culture/sensitivity. See Australian Antibiotic Guidelines.
- Manage co-existent acute / chronic sinusitis

WHEN TO REFER?

Emergency

Patient with diagnosis of acute exacerbation of Bronchiectasis

Urgent

Specialist assessment and management required for patients suspected of having severe Bronchiectasis

BACK

AIRWAY DISEASE (cont'd)

ASTHMA

Initial GP Work Up

Patient history:
- Breathlessness, tightness, wheezing and cough
- Recognition of severity

Investigations:
- Spirometry with bronchodilator reversibility
- FBE, IgE

Management Options for GP

Severe:
- High flow oxygen, IV/oral steroids, nebulised beta agonists. Transfer to ED by ambulance
- Consider Adrenaline 200 micrograms SC (= 2ml 1:10,000 or 0.2ml 1:1,000).

Mild to Moderate:
- Prednisone +/- inhaled steroids
- Beta agonists, short &/or long acting
- Education including smoking cessation, action plan etc
- The National Asthma Council handbook is an excellent free online resource.

WHEN TO REFER?

Emergency
- Acute moderate asthma not responding to GP management
- Acute severe asthma (via ambulance) e.g. coexistent pneumothorax or pneumonia, silent chest, cardiovascular compromise, altered consciousness, relative bradycardia or decreasing rate and depth of breathing
- Asthma with intercurrent disease e.g. Pneumonia

Urgent
- Asthma not readily controlled in GP setting
- Any feature of severe asthma (e.g. requiring frequent courses of prednisone)
- Frequent after hours attendance (ED or GP after hours service).
- Asthma with additional lung disease (e.g. Bronchiectasis, COPD)
- Asthma (i.e. uncertainty about diagnosis)
- Oral prednisolone requirements in community

BACK

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Initial GP Work Up

Patient history:
- History of smoking
- Exercise tolerance, functional capacity (Activities of Daily Living)
- Cough and sputum
- R) heat failure
- Consider common co-morbidities: anxiety, depression, cardiovascular, osteoporosis

Investigations:
- Spirometry, reversibility, gas transfer
- Chest X-Ray
- FBE
- Sputum culture

Management Options for GP
- Smoking cessation
- Fluvax and Pneumovax
- Bronchodilators: COVID Vaccination, LAMA, LABA, LAMA/LABA
- Inhaled steroids considered for frequent exacerbators, asthma overlap
- Optimise techniques of various drug delivery devices
- Ongoing monitoring
- Nutritional advice
- Pulmonary Rehabilitation – Physiotherapy

WHEN TO REFER?

Emergency
- Acute exacerbations
- Respiratory failure

Urgent
Specialist assessment and management required for:
- Patients with high symptom burden
- Pulmonary function testing
- RSV vaccines
- Physiotherapy assessment/pulmonary rehab
- Frequent exacerbations
- Home oxygen assessment
- Right heart failure

Routine
Pulmonary function testing

BACK

INFECTION - LUNG

UPPER RESPIRATORY TRACT INFECTION

Initial GP Work Up

Patient history:

- Smoking
- Inhalation of irritants
- Relevant past respiratory history e.g. asthma

Investigations:

- Chest X-Ray
- Sputum M & C

Management Options for GP

- Cessation of smoking
- Symptomatic treatment
- Broad spectrum antibiotics
- Consider flu vaccination for recurrent attacks

WHEN TO REFER?

Emergency

- Refer for hospital admission for significant co-morbidities:
- Consider admission for significant co-morbidities

Routine

Specialist assessment and management not usually required

BACK

PNEUMONIA/LOWER RESPIRATORY TRACT INFECTION

Initial GP Work Up

Patient history:

Standard history and examination with particular emphasis on the following:

- Respiratory rate, pulse, blood pressure and confusion
- Significant co-morbidities (diabetes, cardio-respiratory)
- Social circumstances

Investigations:

- Chest X-ray may be considered at presentation and 6-8 weeks post treatment
- Sputum M & C
- FBE, CRP

Management Options for GP

- Manage at home/community
- Appropriate broad spectrum antibiotics (see Therapeutic Guidelines)

WHEN TO REFER?

Emergency

Features of sepsis / hypoxaemia

Urgent

- If Chest X-ray change unresolved
- Severe pneumonia (CURB65 or other scale)
- CURB65 score of 2 or more usually require hospital management
- Failure to resolve satisfactorily in the community

Routine

Follow up CT Chest with contrast particularly in smokers or history of malignancy prior to referral

BACK

NEOPLASIA - LUNG

LUNG CANCER, MESOTHELIOMA

WHEN TO REFER?

Initial GP Work Up

Patient history:

- May be asymptomatic
- Most common symptoms if present are persistent cough, shortness of breath, chest pain, weight loss, and systemic symptoms.
- At risk group includes, among others:
  - Smokers or ex-smokers
  - Occupational exposures, particularly asbestos exposure (plumbers, builders, mechanics, ship engineers, railway engineers, wharfies, and truckies)

Investigations:

- Chest X-Ray
- CT Chest

Management Options for GP

N/A

Emergency

Significant breathlessness, significant haemoptysis or difficult to control pain.

Urgent

All suspected malignancy needs to be referred and reviewed within 2 weeks of initial referral.

Routine

Likely benign lung nodules are usually monitored for a period of time with serial imaging.

BACK

LUNG NODULES

WHEN TO REFER?

Initial GP Work Up

Patient history:

- Lung nodules are a frequent incidental finding on CT scans often in the absence of symptoms and can cause severe anxiety. There are well-defined society endorsed guidelines for the management and follow up/surveillance of these findings (please see Fleischner Society Guidelines).
- The National Lung Cancer Screening Program launched on 1 July 2025 (please see https://www.health.gov.au/our-work/nlcsp/about for eligibility criteria). As per statewide referral criteria, patients with high or very high risk lung nodules should be referred (https://www.health.vic.gov.au/statewide-referral-criteria/lung-nodules).

Investigations:

CT Chest

Management Options for GP

- Incidentally detected lung nodules < 6 mm: Please see Fleischner Society Guidelines
- Low and moderate risk lung nodules detected through the National Lung Cancer Screening Program: Please monitor in accordance with the National Lung Cancer Screening Program nodule management protocol: https://www.health.gov.au/sites/default/files/2025-04/national-lung-cancer-screening-program-nodule-management-protocol_0.pdf

Urgent

- Incidentally detected lung nodules ≥ 8mm or associated with suspicious features for malignancy.
- High (category 5) or very high risk (category 6) lung nodules detected through the National Lung Cancer Screening Program.

Routine

Incidentally detected lung nodules < 6mm are usually benign and not routinely assessed in the lung nodule clinic unless for a specified reason. Please refer to the Fleischner Society Guidelines for further information: https://pubs.rsna.org/doi/full/10.1148/radiol.2017161659

BACK

PARENCHYMAL – LUNG DISEASE

PULMONARY FIBROSIS

Initial GP Work Up

Patient history;

- Breathlessness, dry cough, exercise intolerance
- Clubbing may be present
- Fine crackles on examination

Investigations:

- Restrictive spirometry, gas transfer
- Chest X-ray
- HRCT (non-contrast)
- Connective tissue disease screen: ANA, ENA, ESR, ANCA, dsDNA, anti-CCP and RF
- Occupational history: asbestos, silica dust, chemicals

Management Options for GP

May need bronchoscopic evaluation prior to treatment

WHEN TO REFER?

Emergency

- Acute ILD exacerbation can herald a rapid decline
- Usually managed in hospital

Urgent

Rapid referral for progressive decline in exercise tolerance

Routine

Urgent spirometry and non-contrast HRXT evaluation required for all suspected ILD patients

BACK

SARCOIDOSIS

Initial GP Work Up

Patient history:

Often asymptomatic (may present with respiratory or extrathoracic symptoms, e.g. skin, joints, eyes)

Investigations:

- Chest x-ray (changes compatible with diagnosis).
- ESR, Calcium, LFT, FBC
- ACE (debated utility)
- Spirometry and TLCO

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Exacerbation ILD or rapid progression of pulmonary or visual symptoms

Urgent

Progressive symptomatology

Routine

Lung function and initial review.

BACK

PLEURAL DISEASE

PLEURAL EFFUSION

WHEN TO REFER?

Initial GP Work Up

Patient history:
Breathlessness and symptoms and signs of underlying condition e.g. heart failure, neoplasia and infection

Investigations:
- Chest x-ray
- LDH, FBE, total protein, LFTs
- Consider: echocardiogram if cardiac history or cardiac symptoms
- Consider :CT chest if features of malignancy or infection

Management Options for GP
N/A

Emergency
Rapidly accumulating or significant symptomatology at rest

Urgent
Symptomatic large pleural effusion

Routine
All newly diagnosed effusions should be referred for investigation

BACK

PNEUMOTHORAX

WHEN TO REFER?

Initial GP Work Up

Patient history:
Sudden onset of chest pain and/or breathlessness

Investigations:
Chest x-ray

Management Options for GP
Consider development of tension pneumothorax requiring immediate drainage. This is associated with haemodynamic compromise and is a medical emergency requiring intervention.

Emergency
All acute pneumothorax patients need emergency department assessment

BACK

PLEURAL PLAQUES

WHEN TO REFER?

Initial GP Work Up

Patient history:
- History of asbestos exposure.
- At risk occupational groups include: plumbers, builders, mechanics, ship engineers, railway engineers, wharfies, and truckies

Investigations:
Chest x-ray

Management Options for GP
N/A

Urgent
Not required unless additional findings of ILD or pulmonary or pleural malignancy

Routine
Ongoing monitoring of pleural plaques is considered in selected patients

BACK

UNDIFFERENTIATED CHRONIC COUGH

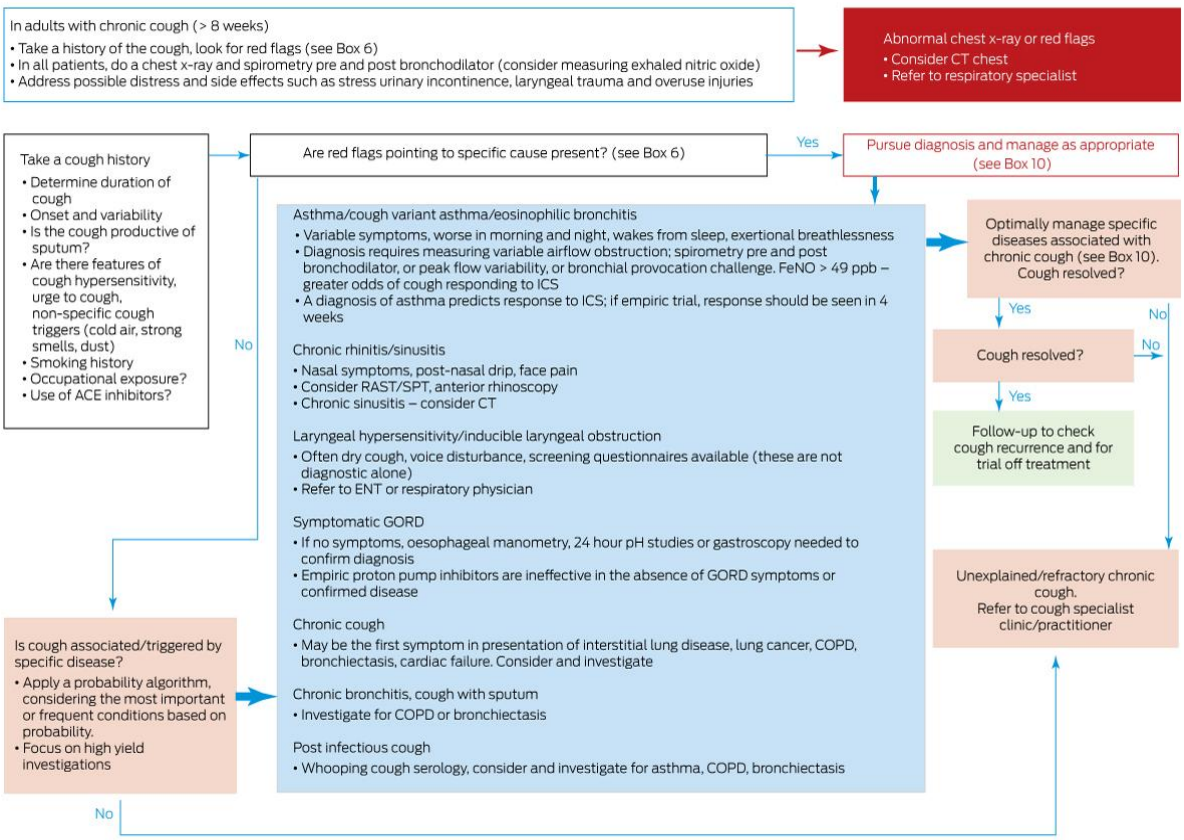
UNDIFFERENTIATED CHRONIC COUGH

Unfortunately, due to the high volume of referrals, our clinics are no longer able to offer an appointment to patients with undifferentiated chronic cough.

Please refer to the following information from Cough in Children and Adults: Diagnosis, Assessment and Management (CICADA). Summary of an updated position statement on chronic cough in Australia (Marchant J et al, Med J Aust 2023; doi: 10.5694/mja2.52157): https://www.mja.com.au/journal/2023/220/1/cough-children-and-adults-diagnosis-assessment-and-management-cicada-summary

ALGORITHM FOR DIAGNOSIS & ASSESSMENT OF AN ADULT WITH CHRONIC COUGH

ACE = angiotensin-converting enzyme;
COPD = chronic obstructive pulmonary disease;
CT = computed tomography;
ENT = ear, nose and throat;
ICS = inhaled corticosteroids;
FeNO = fractional exhaled nitric oxide;
GORD = gastro-oesophageal reflux disease;
ppb = parts per billion;
RAST = radioallergosorbent test;
SPT = skin prick test.



Indicators of Serious Pathology in Adults

- Haemoptysis
- Smoking/vaping (especially new/altered cough, cough with voice disturbance)
- Prominent dyspnoea (especially at rest or at night)
- Chronic productive cough with substantial sputum production
- Hoarseness
- Recurrent pneumonia
- Systemic symptoms: fever, weight loss
- Swallowing difficulties (including choking/vomiting)
- Abnormal clinical respiratory examination (eg, crackles, wheeze, digital clubbing)
- Abnormal chest radiograph

BACK

SLEEP DISORDERS

OBSTRUCTIVE SLEEP APNOEA

WHEN TO REFER?

Urgent

Significant daytime sleepiness affecting daily functioning

Routine

Any patients with suspected OSA for routine workup

Initial GP Work Up

Patient history:

- Snoring, observed apnoeas, daytime sleepiness, morning headaches, waking unrefreshed
- Concomitant obesity, hypertension
- Driving history, particularly commercial drivers licence
- Patients with enlarged tonsils or significant nasal obstruction can also be referred to ENT

Investigations:

- Epworth Sleepiness Scale
- STOP-BANG questionnaire

Management Options for GP

- Continuation of CPAP
- Obesity management

BACK

PARASOMNIAS

WHEN TO REFER?

Urgent

- Concerns about patient safety

Initial GP Work Up

Patient history:

- Sleep-related injurious or disruptive behaviour
- Confusional arousals, sleep walking or sleep terrors
- Social circumstances

Investigations:

- In-lab PSG

Management Options for GP

- Risk minimisation including sleeping separately from bed partner while awaiting specialist review

BACK

NARCOLESY & DISORDERS OF CENTRAL HYPERSOMNIA

WHEN TO REFER?

Emergency

- Features of cataplexy

Urgent

- Specialist input required for diagnosis and management
- Sleepiness causing occupational or driving risk

Initial GP Work Up

Patient history:

- Excessive daytime sleepiness with sleep attacks
- Features of cataplexy
- Hypnogogic (at sleep onset) or hypnopompic (on awakening) hallucinations
- Sleep paralysis

Investigations:

- Diagnostic sleep study with MSLT

Management Options for GP

- N/A

BACK

SLEEP DISORDERS

INSOMNIA

WHEN TO REFER?

Routine

Persistent insomnia despite basic management or insomnia impacting daily functioning

Initial GP Work Up

Patient history:

- Difficultly falling asleep or remaining asleep
- Daytime impairment related to nocturnal sleep difficulty
- Medications and substance use
- Consider common co-morbidities: anxiety, depression

Investigations:

- 2 week sleep diary

Management Options for GP

- Behavioural techniques including regular sleep and wake times, regular morning exercise, avoiding daytime naps, avoiding caffeine after 3pm, switching off screens 30mins before bed
- Melatonin 2mg nocte
- Referral to psychologist specialising in cognitive behavioural therapy for insomnia (CBT-i)

BACK

CIRCADIAN AND SHIFT-WORK DISORDER

WHEN TO REFER?

Routine

Circadian or shift-work disorder

Initial GP Work Up

Patient history:

- Timing and duration of sleep including naps
- Daytime sleepiness or insomnia
- Impairment in social or occupational functioning
- Alcohol and caffeine intake

Investigations:

- 2 week sleep diary

Management Options for GP

- Planned sleep schedule
- Timed light exposure
- Melatonin
- Stimulants (including caffeine) for shift workers

BACK