Principles

General Medicine (GM) is primarily an acute admitting medical service but we also offer a limited outpatient service for both new patients and for follow up of discharges. Unfortunately because of limited funding and resources we can only see a proportion of the cases currently being referred.

GM provide a consultation service. We are not able to provide long term follow up for complex cases.

These guidelines have been developed to help try and provide guidance to both GPs and hospital doctors about what patients could be referred to GM for an outpatient opinion. Please note GM **cannot** see patients who are more appropriately seen by a subspeciality but who have been declined.

Waikato Hospital already has comprehensive **Speciality Referral Guidelines** that were developed to give guidance to hospital RMOs on the appropriate speciality for referrals for admission. They aim to ensure patients are referred to the most appropriate service. The guidelines apply to acute referrals by GPs but they can also help guide what is the most appropriate service for outpatient referrals.

Referral Process, Prioritization

GM has made a commitment to respond to all out patient referrals within 3 working days of receiving the referral in the department. We are using the Best Practice Decision Support application and are processing GP referrals electronically. Options considered by the consultant vetting referrals include:

- accepting the referral and prioritising appropriately to one of 'urgent', 'semi-urgent' or 'routine',
- accepting the referral if it is a request for 'advice only' and providing written advice,
- declining the referral and, if using the Best Practice application, using the following options:
    - indicating the referral cannot be seen with our current resources,
    - redirecting the referral to a more appropriate service,
    - asking for more information or suggest further work-up before an appointment is offered,
    - offering advice and an explanation if it is felt an assessment will not help.

If a referral is declined because of resource limitations we will suggest alternative options which will usually be either recommendations that the referrer could follow or a suggestion for a private referral.

The Best Practice application does not currently allow for a response to be sent to the patient and we would ask the referrer contact the patient to make alternative arrangements to deal with their problems.

If any referrer is unhappy with the response they should contact the GM Business Manager and/or CD.

Clinical Priority Access Criteria and Waiting Times

Because of the nature of many GM referrals it has been difficult to develop clinical priority access criteria to decide who we are able to see with our limited resources and on the priority.

A judgement will be made on the basis of the clinical information provided so it is important that the referral contains adequate details. Referrals may be returned if they do not have enough information.

We will always consider the impact of the illness of the patient's quality of life and function (so please indicate this) and will also assess the likely benefit of a General Medical assessment on their outcome.

Unfortunately many patients with long standing problems and/or chronic disease and/or multiple co-morbidities and/or unlikely to benefit from an assessment cannot currently be offered an appointment.

Referrals of patients with likely malignancy, or life or organ threatening disease, will be prioritized urgent. Patients with new significant problems and/or most likely to benefit will be prioritized semi-urgent. Other cases will be prioritized as routine. We will try and ensure referrals are seen within the target time frames which are shown below. Currently the waits are:

Urgent: 2 weeks Semi-urgent: 6 weeks Routine: 4 months

Appropriate Referrals

Most individuals referred for a specialist medical opinion should be referred to a specific subspeciality but it may be more appropriate to refer some patients to GM outpatients including those with:

- undifferentiated and/or non-specific presentations,
- multiple co-morbidities, or
- no clear or specific speciality for the problem.

Refer to the **Map of Medicine** guidelines for additional recommendations. You need your own log in.

Patients with the following more specific problems could also be referred to General Medicine.

➢ Chest pain, Shortness of Breath, Palpitations and Syncope

The **Cardiology Primary Care Guidelines** suggest patients with chest pain, shortness of breath, palpitations and syncope or pre-syncope be referred to GM if they have:

- chest pain that is unlikely to be cardiac,
- non-specific shortness of breath not likely to be due to a cardiology cause,
- suspected heart failure but a normal BNP,
- palpitations without a documented arrhythmia,
- syncope or pre-syncope of uncertain cause with normal neurological and cardiological findings.

We are no longer able to see most of these referrals and will only see those patients most likely to have significant pathology and those most likely to benefit, based on the information provided.

Patients with murmurs thought to be significant should be referred to Cardiology for echocardiography.

➢ Hypertension

If there is evidence of malignant hypertension or a hypertensive emergency with rapidly progressive end-organ damage refer the patient urgently for admission.

Patients with the following problems could be referred to outpatients:

- resistant and severe hypertension despite multiple drug therapy,
- unusually variable BP,
- if 'white coat' hypertension is suspected and GP unable to organise ambulatory BP monitoring.

Patients with suspected secondary hypertension and young (<35) patients should initially be investigated in Primary Care. GM can help with advice or if tests cannot be organised. See the GM **Hypertension Referral Guidelines** and the **Map of Medicine** for details. Please refer to Renal if the patient has kidney disease, or to Endocrinology if investigation has suggested an endocrine cause.

➢ Possible Malignancy or likely Metastases with Uncertain Primary

If localising features suggesting a likely primary are present, the patient should be referred to the most relevant service for their presenting symptoms and signs. For example to:

- Respiratory if pulmonary symptoms or signs or an abnormal CXR,
- Gastroenterology or General Surgery or Endoscopy if GI symptoms or signs,
- Urology if GU symptoms or signs, or
- Neurosurgery if CT suggests a primary brain tumour.

Gastroenterology will see patients with liver lesions suggestive of malignancy detected on ultrasound.

New patients with a possible malignancy **without** localising features suggesting a primary cancer can be referred to GM for further assessment. Such patients could include those with:

- weight loss of uncertain cause.
- Lymphadenopathy of uncertain cause (if neck nodes only consider initial ENT referral).
- CXR suggestive of metastases with no apparent primary.

For patients with weight loss and no other red flags please ensure that a comprehensive dietary history is taken and consider referring to a dietitian. Weight loss is rarely the only finding in malignancy.

➢ Fatigue and Lethargy

Because of our limited resources, GM can no longer offer assessments for all patients with suspected Chronic Fatigue Syndrome unless there are significant concerns about the diagnosis.

➢ Non-Acute Electrolyte Disturbances

GM can offer advice for patients with significant electrolyte disturbances if a preliminary workup does not suggest a likely cause or a more appropriate referral speciality, for example patients with a high calcium and a high PTH should be referred to Endocrinology. Many patients will not need to be seen.

➢ Anaemia and Anaemia of Uncertain Cause

Consider a direct referral for endoscopy in patients with iron deficiency anaemia and suspected GIT blood loss (as noted below) or no other explanation (diet, malabsorption, menorrhagia, other bleeding).

It may also be more appropriate to get a Haematology opinion first if the patient appears to have an underlying blood disorder like haemolysis, marrow aplasia or myelodysplasia.

GM will see new symptomatic significantly anaemic patients if the cause is uncertain despite a work-up. However if the anaemia is complicating a condition more appropriately managed by a speciality service, or if the patient is known to another service and has a secondary anaemia, refer to that speciality.

For patients with very symptomatic anaemia who require urgent blood transfusion and a diagnostic work-up and who have not previously been assessed and/or do not have a definitive diagnosis, contact the on call GM registrar to organise admission and investigation.

For symptomatic patients who have already been assessed and are on the Meade Day Care (MDC) list for 'top-up' transfusions call MDC to arrange elective transfusion. See the GM **Anaemia** guidelines.

➢ Iron Deficiency

Consider direct referral for endoscopy for iron deficient anaemia with suspected GIT blood loss or 'red flag' gastrointestinal symptoms, and in all men and post-menopausal women with an iron deficient anaemia of no apparent cause. In pre-menopausal women with no gastro intestinal symptoms or red flags start oral iron and consider a Gynaecology referral, if indicated, for menorrhagia or PV bleeding.

Consider a coeliac screen first in patients without evidence of GI bleeding or another cause.

If the patient is a vegetarian and has no 'red flags' start with oral iron and refer for a dietician's opinion.

GM will still accept GP referrals for assessments for parenteral iron therapy in patients with iron deficiency of known cause (**not** requiring further investigation) if they are intolerant of oral iron or have had a poor response to oral iron, for example post gastric surgery or with known malabsorption.

We hope that in the future iron infusions will be funded in the community without the patient needing to be seen or assessed. The **Map of Medicine** will give details of how to organise this.

Patients under DHB specialists can be referred directly to MDC. See the GM **Anaemia** guidelines.

➢ Headache

Refer to the **Headache Primary Care** guidelines developed by Neurology. GM not see out patients whose primary problem is headache. A CT can be requested by GPs for patients with any 'red flags'.

➢ Dizziness and Vertigo

See the syncope section above if the dizziness is thought to be pre-syncope.

Refer for an ENT opinion if the patient has vertigo and any deafness or tinnitus.

Refer to Neurology if there any localising neurological features.

➢ Transient Ischaemic Attacks or minor Stroke

Refer to **Map of Medicine** for guidelines.

If presenting within **4 days** of the TIA or multiple events refer to the GM registrar on call for the day.

If presenting after 4 days or more refer to Neurology outpatients.

➢ Patients > 65 with Frailty, Falls, Memory issues or suspected Dementia

Refer to the Older Persons' service for assessment by a Geriatrician or to the memory clinic.

Referrals of inpatients for follow-up

GM patients who could be discharged if they are able to be followed up within a few days can be brought back to the AMU for review. This **must** be pre-arranged with the AMU CNM.

Patients have to come through ED to get their charts and entered onto the system.

They should be given a day and time, preferably in the morning.

A member of the team they were under must be available to see them.

To arrange a GM clinical appointment for other patients, use the yellow referral form. In the future we may have electronic referrals using the Best Practice Decision Support application.

Please give adequate details to allow the patient to be prioritised and indicate the reason for the referral and which consultant has recommended it and/or which consultant should see the patient.