Waikato District Health Board	Type: **Guideline**	Document reference: **5295**	Manual Classification: **Service Specific Emergency Medicine Administration**	
Title: **Speciality Referral Guidelines**			Effective date: **16 April 2014**	
Facilitator sign/date	Facilitator sign/date	Authorised sign/date	Version: **02**	Page: **1 of 9**
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1. Purpose of Guideline

To give guidance to RMOs on the appropriate speciality for referrals for assessments and admission and so help avoid debates and disputes about which speciality should see a patient

2. Background

The following rules have been adapted from the Waikato Hospital Emergency Department Standard Operating Procedure, signed off by the Waikato Hospital Management Executive Group in 2009.

These guidelines have been developed to ensure patients are referred to the most appropriate service for ongoing management of their identified diagnoses, or presenting problems.

These guidelines recognize the areas of expertise of each of the services, but are not meant as a substitute for clinical judgment. Individual circumstances may alter referral choices.

The guidelines focus on diagnoses in which expertise may overlap, or where there are subspecialty divisions specific to Waikato, so the appropriate service may be unclear. If there is still uncertainty about the most appropriate service the ED consultant should make the recommendation.

Because of the subspecialty split in Medicine it can be particularly confusing about which medical speciality takes which patients in Waikato. See the **Appendix** for more details.

To improve continuity of care, "failed discharges", or patients who have recently been discharged, should normally be referred back to the service they were under, unless they clearly have a new problem that is best managed by another service.

Direct GP to ED Referrals

The same guidelines also indicate which services GPs and Accident and Medical Practitioners should refer to, but note that the ED also accepts direct GP referrals of patients with the following conditions:

- uncomplicated cellulitis suitable for outpatient treatment
- uncomplicated DVT suitable for outpatient treatment
- fractures and dislocations suitable for reduction in ED
- simple abscesses suitable for I&D in ED
- head injury with concussion
- headache and migraine
- suspected renal colic for diagnostic workup
- poisoning and overdose

However, if the patient is not suitable for ED or outpatient management or does not respond and needs admission, then the patients should be referred on to the appropriate speciality listed.

Disagreements and Disputes

A recent memo from the Chief Medical Advisor and the Group Manager on "**The Transfer of Care from ED to Inpatient Specialities**" outlines the protocol that governs all referrals. This notes:

- Inpatient speciality registrars are expected to make a timely assessment of any patient referred.
- A speciality registrar cannot decline to see a referral. Patients must not be kept waiting in the ED.
- If, after seeing a patient, the inpatient speciality team then believe another service is more appropriate it is their (not ED's) responsibility to refer on to the appropriate team.
- Any arguments should be immediately escalated to the Consultant and/or CD level to resolve.

See the Memo on "**Working in the Emergency Department**" for further details about working in ED.

CHILDREN

Paediatric Medicine sees all children with medical conditions up to their 15th birthday.

In occasional circumstances Paediatrics may take certain patients beyond their 15th birthday if they have a chronic life-long condition and are still managed long term as outpatients under the service.

Paediatric Surgery sees most surgical and traumatic conditions in children up to their 15th birthday.

Paediatric Surgery usually manages (with exceptions noted):

- Trauma except those single system conditions managed by other services:
  - Orthopaedics manage fractures/dislocations/spinal injuries
  - Maxillo-Facial manage facial injuries
  - Plastics manage hand injuries
- Abdominal and thoracic surgical conditions, for example acute surgical abdomen, diaphragmatic hernia, empyema, pneumothorax, incarcerated herniae
- Genito-urological issues: testicular/ovarian torsion, urinary calculi, PUJ obstruction with pain
- Inhaled/ingested foreign bodies requiring endoscopic removal (bronchoscopy, oesophagoscopy)
- VP shunt issues/ hydrocephalus if previously under Paediatric Surgery (otherwise Neurosurgery)

Paediatric Surgery does not manage:

- Wounds that can be treated by the ED under ketamine or similar sedation
- Constipation in the rare instance that inpatient consultation is required this should be dealt with by Paediatric Medicine
- UTI, D&V which should be managed by Paediatric Medicine

ADULTS

PROBLEM	SERVICE	DETAILS AND EXCEPTIONS
Abdominal Pain	**General Medicine**	Pyelonephritis, UTI, gastro-enteritis
	Urology	***Proven*** ureteric stone requiring admission
	O&G	Gynaecological cause or due to confirmed pregnancy
	General Surgery	All other patients with abdominal pain
Acute Arthritis	**Orthopaedics**	Suspected septic arthritis
	General Medicine	Gout or rheumatological condition
Alcohol/Drug Withdrawal	**Community Drug & Alcohol Service**	CADS normally only take elective referrals but they may be called for advice during normal office hours
	General Medicine	Will only admit if severe withdrawal symptoms (see **Link**)
Anaemia	**Relevant Service**	If complicating a pre-existing condition or a non-GIT source of bleeding (e.g. epistaxis or vaginal bleeding)
	General Medicine	If suspected occult GIT blood loss or of unknown cause and requiring admission
Aortic Dissection	**Cardiothoracic Surgery**	Involving ascending aorta/arch ("Type A")
	Cardiology	Distal to left subclavian artery ("Type B")
	Vascular Surgery (as well as above)	Type A or B with end organ ischemia (E.g. mesenteric, renal, lower extremity)

Back Pain	**Orthopaedics**	Take patients with back pain if due to acute trauma, or if there are signs of cord compression, and also patients with back pain and sciatica (if requiring admission)
	Neurosurgery	Take patients with back pain due to extradural or intradural infection with or without any neurological deficit

There is considerable overlap between orthopaedic spinal surgical and neurosurgical expertise in acute spinal pathology. This includes:

- cauda equine injury or disease
- pathalogical fractures due to tumours
- osteoporotic collapse with instability

If any doubt exists as to extent of spinal involvement then potentially BOTH Orthopaedic and Neurosurgical services must be acutely initially notified

	OP&RS (AT&R)	During office hours, and if there is an available bed, OP&RS will take patients over age 65 with pain due to stable vertebral fractures. See the **Appendix** for details
	General Medicine	Take patients with back pain due to osteoporotic collapse without instability, or back pain secondary to metastases if not known to another service (eg Oncology)
Cellulitis/Soft Tissue Infection	**Note multidisciplinary input will be required for necrotising fasciitis**	
	Plastics	Hand, forearm and scalp Necrotising fasciitis (with other surgical specialties as required)
	ORL	Pharyngeal abscess: • Retropharyngeal • Parapharyngeal (peritonsillar) Complications of sinusitis: • Periorbital sinusitis • Ethmoidal sinusitis Abscesses that threaten airway, eg Ludwig's angina
	Orthopaedics	Proven or highly likely bone/joint infection Infected joint prosthesis Infective bursitis (knee/elbow)
	Vascular	Arterial or venous ulcers with infection Diabetic foot sepsis or limb sepsis Infected vascular grafts and associated infections
	General Surgery	Breast cellulitis or abscess, Pilonidal or ischio-rectal abscesses. Truncal abscess Superficial abscess with associated infection including limbs (not covered elsewhere)
	Ophthalmology	Orbital and peri-orbital

	Maxillo-Facial	Dental abscesses Head and neck soft tissue infection Face Intra-oral cellulitis and Ludwig's angina (with ORL advice if required)
	Neurosurgery	Post operative facial and scalp cellulitis Forehead cellulitis due to frontal sinus infection Cavernous sinus thrombosis
	General Medicine	Cellulitis of limbs and trunk without abscess (and not involving head and neck, hands, joint or other areas like scrotum, peri anal, vulva, breast) Lymphangitis Complex dermatological conditions with cellulitis. Sacral pressure sores (with Plastics input)
	Urology	Scrotal cellulitis or abscess
	Gynaecology	Vulval cellulitis and abscess
Chest Pain	**Chest Pain Unit**	Likely/possible cardiac chest pain but at low risk. Pain must have resolved and be the only problem. CPU admission is to assess for further tests and is not appropriate if the patient has other issues.
	Cardiology	ACS or cardiac chest pain at high risk, eg dynamic ECG changes or raised troponin. Note that a raised troponin without ECG changes and chest pain and/or in unwell patients with other conditions in whom invasive cardiac intervention is not part of the anticipated care does not mandate Cardiology referral
	Respiratory	Pleuritic chest pain or possible PE
Collapse/Falls	**OP&RS (AT&R)**	During office hours and if there is an available bed, OP&RS will take patients who have: • recurrent falls, • problems with mobility, • a fracture not requiring orthopaedic intervention, • pain due to stable vertebral or pelvic fractures, as long as they are medically stable and do not have an acute medical problem. See the **Appendix** for details
	General Medicine	General Medicine will admit patients who have a medical cause of falls or their injury (eg seizure, syncope) and/or need medical management
	Cardiology	Refer to Cardiology if collapse is due to a documented arrhythmia or very likely to be due to an arrhythmia
	Orthopaedics	Orthopaedics will admit patients who are unable to mobilise because of severe pain after an injury caused by a mechanical fall or trauma (with or without fracture) unless they have a concurrent active medical problem requiring inpatient management

Constipation	**General Surgery**	
COPD/Asthma	**Respiratory**	
Delirium	**Relevant Service**	Patients with delirium secondary to an identified cause should be admitted under the appropriate service (eg if pneumonia admit under Respiratory)
	General Medicine	Delirium of uncertain cause or caused by a medical condition appropriate to GM (eg UTI or cellulitis)
DVT (but no PE)	**General Medicine**	If significant co-morbidities and/or unsuitable for outpatient treatment (eg high femoral or iliac DVT)
	Vascular Surgery	With critical limb ischaemia to consider thrombolysis or if high saphenous clot to consider ligation
Diverticulitis	**General Surgery**	
GI Bleeding	**General Medicine**	Upper GI bleed
	General Surgery	Lower GI bleed
Heart Failure	**Respiratory**	Cor pulmonale
	General Medicine	Frail elderly patients with significant co-morbidities
	Cardiology	All other patients
Hepatitis and	**Gastroenterology**	If known to Gastroenterology and during office hours
Liver Failure	**General Medicine**	Patient not known to Gastroenterology or out of hours
Hypertension	**General Medicine**	If not in heart failure
	Cardiology	If complicated by heart failure
	Obstetrics	If >20 weeks gestation (Pre-eclampsia)
Inflammatory BD	**Gastroenterology**	If known to Gastroenterology and during office hours
	General Medicine	Patient not known to Gastroenterology or out of hours
	General Surgery	If evidence of obstruction, perforation or undifferentiated pain of severity requiring admission
Ischemic Limb	**Vascular Surgery**	
Ischemic Colitis	**General Surgery**	
Oncology Issues	**Oncology**	Refer to the relevant Oncology service if the patient satisfies <u>all</u> of the following: a) has a confirmed malignancy b) is currently (or has within the last 6 months been) principally under the care of the Oncology service for that malignancy c) the major current clinical problem is most likely to be related to their malignancy (or the treatment of that malignancy)

Oncology Issues (continued)

Patients with cancer who do not satisfy the above criteria (including those who present with localising symptoms or signs suggesting a new primary cancer) are almost never admitted under the Oncology service (unless urgent Oncology treatment is to be delivered).

Patients with complications of metastatic disease known to a service should be referred back to that service

New patients with a suspected malignancy should be referred to the most appropriate service for a diagnostic work-up based on their presenting clinical features and/or the results of preliminary investigations. For example to:

Respiratory	If symptoms or signs or a CXR suggesting lung cancer
General Surgery	If GI symptoms or signs suggesting abdominal cancer
Urology	If GU symptoms or signs
Neurosurgery	If CT-proven primary brain tumour
General Medicine	Will take patients with suspected malignancy and no localising features or patients with metastatic disease not already known to a service or with an unknown primary

Palliative Care

The Waikato Hospital Palliative Care (PC) team is not able to accept patients for admission under their care, except in very specific inter-hospital transfer situations, for example patients requiring regional or spinal analgesia.

Patients already under the care of PC +/- Hospice services that require in-patient palliative care will usually be best served by admission to Hospice Waikato In-patient Unit (HWIPU) in Hillcrest. Patients who are thought to potentially be suitable for admission to HWIPU should be discussed with the Palliative Care Consult-Liaison (PCCL) team 0800-1630 Monday to Friday, or the on-call PC SMO if out-of-hours. See **flow chart** for details.

If HWIPU admission is not appropriate (or there is no space available) then patients will be admitted under the most appropriate inpatient team in Waikato Hospital, and the PCCL team will assist both in discussion of the most appropriate disposition and also in that patient's care. The most appropriate admitting team is best decided by the involved SMOs (on-call SMOs out-of-hours) for each individual situation, but some common principles apply:

a) If the patient is currently (or has within the last 6 months been) principally under the care of a clinical service and their major current problem(s) is most likely to be related to their underlying diagnosis for which they have been managed by that service, they should be admitted under that service.

b) If a) above is not satisfied, then the patient should be admitted under the clinical service most appropriate to address the patient's current needs, such as outlined in the Oncology section above or in the relevant sections for non-malignant conditions. See

Patients who may be suitable for PC team input but are not already under the care of PC +/- Hospice services can be discussed with PCCL team from 0800-1630 Monday to Friday. Outside these hours, no acute new referrals can be made. Routine referrals for community input can be made by forwarding a standard internal referral to the PC team. See **flow chart** for details.

Pancreatitis	**General Surgery**	
Pregnancy	**Relevant Service**	Pregnant patients should be admitted under the most appropriate service for their presenting problem but always notify the Obstetric service about pregnant patients admitted with a significant illness or injury
Psychosis, Depression, Mood Disorder and Disordered Behaviour	**Psychiatry**	Presentation of acute, or exacerbation of a chronic, psychotic condition and no organic cause identified If there is an organic cause or **Delirium** see above. During office hours contact Consult-Liaison Out of hours contact the CAT team Security must also be called at the same time if the patient is disruptive, aggressive or violent.
PE (+/- DVT)	**Respiratory**	
Pneumonia	**Respiratory**	And other chest infections (bronchitis) needing admission
Pyelonephritis	**Urology**	Obstructing ureteric stone or hydronephrosis Prostatitis
	General Medicine	All other UTIs requiring admission
Renal Failure	**Renal**	If already known to Renal or if new onset of acute kidney injury and urgent dialysis required
	General Medicine	New onset acute kidney injury and urgent dialysis not required or chronic renal failure not known to Renal
Stroke/TIA	**Neurology**	Possible candidate for thrombolysis eg stroke presenting within 4 hours of symptom onset
	Neurosurgery	Intracerebral haemorrhage possibly amenable to surgery (eg posterior fossa, localised haematoma) Large hypertensive bleeds with fluctuating LOC in <65 year olds should be discussed with Neurosurgery
	General Medicine	All other strokes, TIAs and ICH not for surgery
Subarachnoid/ Subdural	**Neurosurgery**	May, by mutual agreement, be referred to General Medicine if for a palliative care approach
Suicidal Attempt/ Overdose	**General Medicine**	If needs admission or unsuitable for ED management All patients should have a psychiatric risk assessment During office hours contact Consult-Liaison During evenings call the CAT team Over night contact the duty psychiatric registrar
Syncope/Seizures	**Cardiology**	Suspected arrhythmia
	General Medicine	All others
Transplant Patients	**Relevant Service for presentation**	But the appropriate service following up the transplant patients must also be consulted

Trauma	**General Surgery** is the default admitting service for all patients with multiple and severe injuries. The **Trauma Team** should also be notified. Single system injuries should be admitted under the service responsible for that injury. This may include patients with more than one injury as long as their secondary injuries are within the realm of the admitting service to deal with primarily or by consultation. Consults are requested from the same services.	
	Cardiothoracic	Thoracic injury (penetrating, blunt)
	General Surgery	Abdominal injury (penetrating, blunt)
	Orthopaedics	Extremity fracture or ligamentous injury Pelvic fracture (unstable) Pelvic fracture of any type unless a fall caused by a medical condition or medical co-morbidities requiring active medical management (see relevant **Memo**) Vertebral fracture, if unstable, or involving cervical spine, or neurological compromise
	Maxillofacial	Facial Fracture
	Vascular Surgery	Vascular injury
	Neurosurgery	Intracranial Haemorrhage
	Plastic Surgery	Upper limb soft tissue injury Hand fractures
	Obstetrics	Should be involved in all pregnant trauma patients, and may or may not be the admitting service depending on other injuries
Urological devices	**Urology**	Significant issues regarding a urological device requiring advice, intervention or admission such as: - ureteric stent, - nephrostomy tube - urethral or suprapubic catheter when the device itself is either the cause of the problem or needs urological intervention

Appendix:

MEDICAL REFERRALS

In the mid-90s acute medical admissions to Waikato Hospital were split into Cardiology, Respiratory and General Medicine. With the further development of the medical subspecialties who gets admitted under what service in Waikato can be confusing and needs to be understood.

Patients with a primary cardiological or respiratory problem should be referred to Cardiology or Respiratory. For example, that means in Waikato patients with acute coronary syndromes, angina, heart failure and arrhythmias are usually admitted under Cardiology and cases of pneumonia, chest infections, COPD, asthma and lung cancer go under Respiratory.

Other patients with an acute medical problem should usually be referred to General Medicine unless they have a condition indicated in the list above. If it is unclear what the primary problem is, refer to General Medicine or discuss with the on-call General Medicine registrar.

Between 0800 and 1600 on weekdays patients with a problem more appropriately managed by another subspecialty, or patients who are under regular review by a subspecialty and present with a related problem, should be referred to that service. Consultants for most subspecialties are available on-call for advice out of hours if it is unclear what is most appropriate.

REFERRALS FOR DIRECT ADMISSION TO AT&R WARDS

Waikato does not have an acute Geriatrics service so refer to the appropriate speciality for the patient's presenting problem.

AT&R will now take some suitable stable patients directly if they have available beds. Patients should not have an acute medical problem. They should not be managing at home for another reason and cannot safely be discharged directly home from the ED or AMU.

The guidelines for direct referral are:

Patients must meet all the following criteria:

1 Be over 65 years.

2 Need rehabilitation, convalescent care or home supports to enable a return home.

3 Be medically stable. AT&R are **not** an acute medical service for older adults.

4 Stable neurologically and not require regular neurological observation.

5 Basic investigations do not show abnormalities which do not require any action.

6 Patient does not require intravenous fluids or intravenous therapy.

Patients with the following problems are appropriate referrals**:**

1 Fractures that impair function but not requiring orthopaedic intervention.

2 Pain due to stable vertebral or pelvic fractures.

3 Recurrent falls or mobility problems, unless due to an acute illness.

4 Recently discharged from AT&R wards and re-presenting with a similar illness.

5 Well known to our service and not managing at home but not acutely unwell.

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