NSW Health

Adult Gastroenterology State-wide Referral Criteria for Public Outpatient Services

This document is to be used as a guide for referrers and clinicians in NSW public outpatient services

The aim of State-wide Referral Criteria (SRC) is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services.

This document contains Gastroenterology SRC for gastroenterological emergencies, gastroenterological presentations out of scope and the following presenting conditions:

Acknowledgements

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Notes

- Gastroenterology SRC sets thresholds for referral, regardless of source, to NSW public gastroenterology and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services, and the expected clinical urgency category based on clinical need
- Gastroenterology SRC supports patients to be managed by the most appropriate member(s) of the multidisciplinary care team in the most appropriate setting based on their presenting condition
- Gastroenterology SRC are applicable to NSW Local Health Districts and Specialty Health Networks with public gastroenterology and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services that manage the identified presenting conditions
- Gastroenterology SRC are applicable where the identified presenting conditions managed by gastroenterologists and general, colorectal or upper gastrointestinal surgeons are delivered in private practice as part of public-private hospital arrangements
- Gastroenterology SRC may also be used by a range of specialists in private practice at their own discretion
- Gastroenterology SRC does not intend to change eligibility in terms of presenting conditions managed and referral sources accepted for NSW public gastroenterology and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services
- Some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local contextual factors and/or service availability
- Referring health professionals may consider local alternative care options, including private practice, Aboriginal Community Controlled Health Services and/or non-government organisations, where appropriate, for patients seeking to access specialist services

Glossary

The structure for SRC in NSW is divided into the following five criterion.

In some cases, component(s) may not be applicable to each presenting condition. This will be denoted by 'Nil'.

Criterion	Description
Emergency	• Clinical presentations or 'red flags' where referring health professionals should consider redirecting the patient to an Emergency Department or urgent care service, or seeking medical advice (e.g. phone on-call medical practitioner) • These criteria should not be used by referring health professionals to refer to an NSW public specialist outpatient service
Out of scope (not routinely provided)	• Symptoms, conditions and/or presentations that would not routinely be provided by NSW public specialist outpatient services (i.e. could be optimally and safely managed in primary care) • These criteria acknowledge and permit exceptions, where clinically appropriate
Access and prioritisation	• Symptoms, conditions and/or presentations that advise referring health professionals, clinicians, patients and carers suitability for management by NSW public specialist outpatient services • These criteria are classified by expected clinical urgency category and clinically recommended timeframes to be seen for a new outpatient appointment (i.e. Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days) • These criteria are only applicable where NSW public specialist outpatient services exist and manage the identified presenting condition
Required information	• Mandatory information that is to be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category
Additional information (if available)	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

Gastroenterological emergencies

Note: Gastroenterological emergencies require immediate medical attention and/or intervention to prevent or manage serious harm to a patient. The list of emergency criteria below may not be exhaustive. Please refer to HealthPathways for more information.

Presenting condition	Emergency

Abdominal pain (adult)	• Acute severe colitis (e.g. Crohn's disease, ulcerative colitis or infectious) > 6 bloody bowel stools per 24 hours with any of the following:
	  ○ Temperature > 37.8°C
	  ○ Pulse rate > 90 bpm
	  ○ Haemoglobin < 105 g/L
	  ○ Severe abdominal pain
	  ○ Suspected abscess, perforation or megacolon
	• Acute surgical syndrome suspected by symptoms of shock, sepsis or severe abdominal pain with signs suggestive of acute abdomen or jaundice

Cirrhosis (suspected or known) (adult)	• Cholangitis (pain, fever and jaundice) • Cirrhosis with acute clinical decompensation event (e.g. encephalopathy, gastrointestinal bleeding or new onset ascites, especially if with pain, fever or other systemic symptoms) • Liver failure (bilirubin > 100, INR > 2.0) with clinical signs of decompensation
Concern for colorectal cancer (Rectal bleeding or Positive Faecal Occult Blood Test) (adult)	• Melaena or haematochezia, haematemesis or vomiting in large volume or with haemodynamic compromise
Gastrostomy feeding tube problems with blocked or displaced gastrostomy in patients with nil oral route for nutrition or hydration (adult)	• Gastrostomy feeding tube problems with blocked or displaced gastrostomy in patients with nil oral route for nutrition or hydration
Hepatocellular cancer (suspected or known) or liver lesion (adult)	• Nil emergency criteria

Inflammatory bowel disease or irritable bowel syndrome (suspected or known) (adult)	• Suspected or known inflammatory bowel disease with concern for severe or complicated colitis (perforation, toxic mega colon, abscess, bowel obstruction) indicated by:
	  ○ Fever
	  ○ Tachycardia
	  ○ Hypotension
	  ○ Significant abdominal pain or peritonism
	  ○ Abscess (abdominal or perianal)
	  ○ Acute severe colitis: > 6 bloody bowel motions per 24 hours with at least one of the following:

	▪ Temperature > 37.8°C ▪ Pulse rate > 90 bpm ▪ Haemoglobin < 105 gm/L ▪ Raised inflammatory markers (erythrocyte sedimentation rate (ESR) > 30 mm/hr or C-reactive protein (CRP) > 30 mg/L) • Suspected or known inflammatory bowel disease with symptoms suggestive of severe flare of known inflammatory bowel disease accompanied by fever, haemodynamic compromise, significant abdominal pain, suspected megacolon, perforation, bowel obstruction and/or abscess and unable to be controlled in the community
Iron deficiency (adult)	• Melaena or haematochezia, haematemesis or vomiting in large volume or with haemodynamic compromise
Liver dysfunction (adult)	• Liver failure (bilirubin > 100, INR > 2.0) with clinical signs of decompensation
Upper gastrointestinal dysfunction (adult)	• Dysphagia with inability to tolerate oral intake

Gastroenterological presentations out of scope

Presenting condition	Out of scope (not routinely provided)
Abdominal pain (adult)	• Second opinions for conditions already seen by the same specialty • Suspected cholelithiasis or cholecystitis Note: referral to upper gastrointestinal surgery may be indicated.
Cirrhosis (suspected or known) (adult)	• Nil out of scope criteria
Concern for colorectal cancer (Rectal bleeding or Positive Faecal Occult Blood Test) (adult)	• Completed colonoscopy with adequate bowel preparation in the last 2 years for the same symptoms Note: colonoscopy is not required if already performed in the last 2 years and findings were normal (i.e. no polyps) so long as there are no new symptoms or other indication for more frequent colonoscopy. • Fissure surgery Note: referral to colorectal surgery is indicated if medical therapy fails. • Haemorrhoid surgery or banding Note: referral to colorectal surgery is indicated if medical therapy fails. • Persistent but unchanged gastrointestinal symptoms previously investigated
Hepatocellular cancer (suspected or known) or liver lesion (adult)	• Hepatocellular cancer surveillance (when indicated can be conducted in a primary care or specialist setting based on local practice) (see Cancer Council guidelines for more information)
Inflammatory bowel disease or irritable bowel syndrome (suspected or known) (adult)	• Nil out of scope criteria
Iron deficiency (adult)	• Normochromic, normocytic anaemia with normal iron studies or isolated low serum iron Note: clinical monitoring within primary care for anaemia secondary to gynaecological, haematological or other causes. Consider faecal occult blood test. Refer to outpatient services if anaemia is progressive, faecal occult blood test is positive or if gastrointestinal symptoms emerge.
Liver dysfunction (adult)	• Fatty liver with normal liver function tests and Fibrosis-4 (FIB 4) score below 1.3 (meaning no significant fibrosis evident)
Upper gastrointestinal dysfunction (adult)	• Belching • Halitosis

Presenting conditions

Abdominal pain (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.
• Acute severe colitis (e.g. Crohn's disease, ulcerative colitis or infectious) ≥ 6 bloody bowel stools per 24 hours with any of the following:
  ○ Temperature > 37.8°C
  ○ Pulse rate > 90 bpm
  ○ Haemoglobin < 105 g/L
  ○ Severe abdominal pain
  ○ Suspected abscess, perforation or megacolon
• Acute surgical syndrome suspected by symptoms of shock, sepsis or severe abdominal pain with signs suggestive of acute abdomen or jaundice

Out of scope (not routinely provided)
• Second opinions for conditions already seen by the same specialty • Suspected cholelithiasis or cholecystitis Note: referral to upper gastrointestinal surgery may be indicated.

Access and prioritisation	

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Persistent or recurrent abdominal pain > 6 weeks with any of the following concerning features:
	  ○ ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months
	  ○ Iron deficiency or other abnormal blood tests (haemoglobin, C-reactive protein, liver function test)
	  ○ Abdominal mass on examination
	  ○ Abnormal imaging (CT or ultrasound) (e.g. luminal pathology or evidence of biliary obstruction (choledocholithiasis))
	  ○ Nocturnal symptoms disturbing sleep
	  ○ Positive Faecal Occult Blood Test (FOBT)
	  ○ Positive Faecal Immunochemical Test (FIT)
	  ○ Suspected Familial Mediterranean Fever (FMF) disorder
	  ○ Diarrhoea and any critical factor listed in the Inflammatory bowel disease or irritable bowel syndrome (suspected or known) criteria

Category 2 (clinically recommended to be seen within 90 calendar days)	• Persistent or recurrent abdominal pain for > 6 weeks without any of the concerning features listed above

Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - A history of past gastrointestinal (GI) cancer, abdominal surgery
    - If patient is taking non-steroidal anti-inflammatory drugs (NSAIDs), opioids, anti-depressants, selective serotonin reuptake inhibitors (SSRIs), anticoagulants and/or antiplatelets)
    - Examination findings (body mass index, abdominal and digital rectal examination)
    - Full blood count
    - Iron studies
    - Faecal Occult Blood Test (FOBT) and/or faecal calprotectin result (if lower GI symptoms causes are under consideration)
    - Relevant imaging (CT or ultrasound) report

Additional information (if available)

- Family history of GI disease in 1st degree relative – irritable bowel syndrome (IBS), cancer, polyp, inflammatory bowel disease (IBD)
- Smoking status
- Drug and alcohol consumption
- Previous endoscopic procedures (date, report and histology)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Cirrhosis (suspected or known) (adult)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar. • Cholangitis (pain, fever and jaundice) • Cirrhosis with acute clinical decompensation event (e.g. encephalopathy, gastrointestinal bleeding or new onset ascites, especially if with pain, fever or other systemic symptoms) • Liver failure (bilirubin > 100, INR > 2.0) with clinical signs of decompensation	
Out of scope (not routinely provided)	
• Nil	
Access and prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Suspected or known cirrhosis on imaging, non-invasive testing or pathology, and any of the following are present: ○ Decompensation event (current or previous) (e.g. history of jaundice, ascites, confusion, gastrointestinal bleeding) ○ High risk features on laboratory (Child-Pugh score > B7, Model for End-stage Liver Disease (MELD) > 9, platelets < 150) ○ Elevated alpha-fetoprotein (AFP) or space occupying lesion on imaging
Category 2 (clinically recommended to be seen within 90 calendar days)	• Suspected or known cirrhosis on imaging, non-invasive testing or pathology, and any of the following are present: ○ Underlying liver disease identified which cannot be treated in primary care (e.g. viral hepatitis – discretion of referring clinician, haemochromatosis, autoimmune liver disease, primary sclerosing cholangitis) ○ New diagnosis of cirrhosis with no prior specialist assessment or management plan
Category 3 (clinically recommended to be seen within 365 calendar days)	• Routine care for known cirrhosis which requires assessment within 6 months (e.g. hepatocellular cancer surveillance, oesophageal varices screening, nutrition) Note: patients with stable compensated cirrhosis who only require hepatocellular cancer surveillance may be appropriately managed in general practice.

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Alcohol intake
    - Risk factors for viral hepatitis
    - Coagulation profile
    - Full blood count
    - Hepatitis A serology (HAV IgG)
    - Hepatitis B serology (HBV sAg, sAb, cAb, and if HbsAg+, HBeAg/Ab and HBV DNA)
    - Hepatitis C serology (HCV Ab and if Ab+, HCV RNA)
    - Iron studies
    - CT or upper abdomen ultrasound report
    - Current and previous liver function tests

Additional information (if available)

- HbA1c
- Antinuclear antibody (ANA) immunoglobins
- Previous ultrasound, CT or MRI reports
- Previous endoscopy reports
- Vaccination history
- Any relevant family history
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Concern for colorectal cancer (rectal bleeding or positive Faecal Occult Blood Test) (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Melaena or haematochezia, haematemesis or vomiting in large volume or with haemodynamic compromise

Out of scope (not routinely provided)

- Completed colonoscopy with adequate bowel preparation in the last 2 years for the same symptoms
  Note: colonoscopy is not required if already performed in the last 2 years and findings were normal (i.e. no polyps) so long as there are no new symptoms or other indication for more frequent colonoscopy.
- Fissure surgery
  Note: referral to colorectal surgery is indicated if medical therapy fails.
- Haemorrhoid surgery or banding
  Note: referral to colorectal surgery is indicated if medical therapy fails.
- Persistent but unchanged gastrointestinal symptoms previously investigated

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Positive Immunochemical Faecal Occult Blood Test (iFOBT), including those screened through a bowel screening program
	• Aged ≥ 40 years and positive FOBT with any of the following symptoms:
	  ○ Rectal bleeding
	  ○ Change in bowel habit or any lower gastrointestinal symptoms
	  ○ Unexplained anaemia (Hb < Lower Limit of Normal)
	• Aged ≥ 50 years and negative FOBT, but any of the following symptoms:
	  ○ Rectal bleeding
	  ○ Change in bowel habit or any lower gastrointestinal symptoms
	  ○ Unexplained anaemia (Hb < Lower Limit of Normal)
	• Any age and ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months
	• Any age and abnormal imaging concerning for colorectal or upper gastrointestinal cancer

Category 2 (clinically recommended to be seen within 90 calendar days)	• Aged ≤ 39 years and positive FOBT with any of the following symptoms: ○ Rectal bleeding

	○ Change in bowel habit or any lower gastrointestinal symptoms ○ Unexplained anaemia (Hb < Lower Limit of Normal) • Aged 40 to 49 years and negative FOBT, but any of the following symptoms: ○ Rectal bleeding ○ Change in bowel habit or any lower gastrointestinal symptoms ○ Unexplained anaemia (Hb < Lower Limit of Normal) • Age ≤ 49 years old and change in bowel habit with elevated faecal calprotectin (> 100 microgram/g)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Age ≤ 39 years old, negative FOBT with any of the following symptoms: ○ Rectal bleeding ○ Change in bowel habit or any lower gastrointestinal symptoms ○ Unexplained anaemia (Hb < Lower Limit of Normal) • Family history of colon cancer ○ Known or suspected hereditary colon cancer syndrome Note: age for colonoscopy depends on syndrome ○ Suggestive of a moderate or high-risk colon cancer Note: see Cancer Council Guidelines for more information • Personal history of polyps or colon cancer and recommended for repeat colonoscopy (provide Charleston comorbidity index score for age > 75)

Required information

- Reason for referral
- Details of the presenting condition including symptoms and their duration
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Weight loss (amount and timeframe)
  - Patient and family history of gastrointestinal cancer, including age of diagnosis
  - Full blood count
  - Haematinics (iron studies, red blood cell count, folate, vitamin B12)

Additional information (if available)

- Faecal Occult Blood Test (FOBT) result
- Electrolytes, urea and creatinine (EUC)
- Rectal examination result
- Relevant imaging results
- Current and previous colonoscopy results (including histology)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population

- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Hepatocellular cancer (suspected or known) or liver lesion (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Nil

Out of scope (not routinely provided)

- Hepatocellular cancer surveillance (when indicated can be conducted in a primary care or specialist setting based on local practice)
  Note: see Cancer Council guidelines for more information

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Known chronic liver disease and any of the following are present:
	  ○ New lesion (excluding simple cysts)
	  ○ Lesion suggestive of hepatocellular cancer according to radiology report
	  ○ Raised alpha-fetoprotein (AFP)
	• No underlying liver disease but radiology suggests lesion suspicious for malignancy

Category 2 (clinically recommended to be seen within 90 calendar days)	• Other liver lesions (unless imaging strongly suggests benign aetiology)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Coagulation profile test result
  - Full blood count
  - Tumour markers (alpha feto-protein (AFP), carbohydrate antigen 19-9 (Ca 19-9), carcinoembryonic antigen (CEA))
  - Renal function test result
  - Liver function test result
  - Liver imaging result (current and any previous)

Additional information (if available)

- History of underlying liver disease and/or cirrhosis
- Hepatitis B serology (HBV sAg, sAb, cAb)
- Hepatitis C serology (HCV Ab)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Inflammatory bowel disease or irritable bowel syndrome (suspected or known) (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Suspected or known inflammatory bowel disease with concern for severe or complicated colitis (perforation, toxic mega colon, abscess, bowel obstruction) indicated by:
  - Fever
  - Tachycardia
  - Hypotension
  - Significant abdominal pain or peritonism
  - Abscess (abdominal or perianal)
  - Acute severe colitis: > 6 bloody bowel motions per 24 hours with at least one of the following:
    - Temperature > 37.8°C
    - Pulse rate > 90 bpm
    - Haemoglobin < 105 gm/L
    - Raised inflammatory markers (erythrocyte sedimentation rate (ESR) > 30 mm/hr or C-reactive protein (CRP) > 30 mg/L)
- Suspected or known inflammatory bowel disease with symptoms suggestive of severe flare of known inflammatory bowel disease accompanied by fever, haemodynamic compromise, significant abdominal pain, suspected megacolon, perforation, bowel obstruction and/or abscess and unable to be controlled in the community

Out of scope (not routinely provided

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Known inflammatory bowel disease where infectious diarrhoea is excluded (by stool MCS, ova, cysts and parasites, *Clostridioides difficile* toxin) and any of the following are present: ○ Elevated faecal calprotectin (> 100 micrograms/g) ○ New progressive, or warning gastrointestinal symptoms (e.g. abdominal pain, vomiting) ○ Critical factor: - Anaemia - Low albumin - Elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) - Iron deficiency - ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months - Pregnancy ○ New, abnormal imaging

	○ Perianal pain or fistulae suspected • Suspected inflammatory bowel disease where chronic diarrhoea or other suspicious symptoms > 6 weeks with elevated faecal calprotectin (> 100 micrograms/g), and any of the following are present: ○ New progressive, or warning gastrointestinal symptoms (e.g. abdominal pain, vomiting) ○ Laboratory critical factor: - Anaemia - Low albumin - Elevated ESR or CRP - Iron deficiency ○ ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months ○ Abnormal imaging suggesting inflammatory bowel disease
Category 2 (clinically recommended to be seen within 90 calendar days)	• Known inflammatory bowel disease and none of the above critical factors but flare of symptoms • Suspected inflammatory bowel disease where chronic diarrhoea or other suspicious symptoms > 6 weeks with elevated faecal calprotectin (> 100 micrograms/g), and none of the above critical factors or symptoms
Category 3 (clinically recommended to be seen within 365 calendar days)	• Longstanding bowel symptoms suggestive of irritable bowel syndrome with none of the above critical factors, or laboratory or imaging changes • Lower gastrointestinal symptoms (e.g. suspected pancreatic exocrine insufficiency, suspected collagenous or microscopic colitis, faecal incontinence) and seeking specialist advice

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Personal or family history of inflammatory bowel disease
  - Smoking history
  - C-reactive protein (CRP)
  - Electrolytes, urea and creatinine (EUC)
  - Full blood count
  - Iron studies
  - Current and previous colonoscopy results
  - Faecal calprotectin result
  - Liver function test result

- Molecular testing of stool for infection (by stool MCS, ova, cysts and parasites, *Clostridioides difficile* toxin)
- Relevant imaging reports

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Iron deficiency (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Melaena or haematochezia, haematemesis or vomiting in large volume or with haemodynamic compromise

Out of scope (not routinely provided)

- Normochromic, normocytic anaemia with normal iron studies or isolated low serum iron
  Note: clinical monitoring within primary care for anaemia secondary to gynaecological, haematological or other causes. Consider faecal occult blood test. Refer to outpatient services if anaemia is progressive, faecal occult blood test is positive or if gastrointestinal symptoms emerge.

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Aged ≥ 40 years and positive Faecal Occult Blood Test (FOBT)
	• Aged ≥ 50 years old and negative FOBT, but any of the following symptoms:
	  ○ Rectal bleeding
	  ○ Change in bowel habit or any lower gastrointestinal symptoms
	  ○ Unexplained iron deficiency with or without anaemia (Hb < Lower Limit of Normal)
	• Any age and ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Aged ≥ 40 years with all of the following present:
	  ○ Negative FOBT
	  ○ Negative coeliac serology
	  ○ Gastrointestinal symptoms
	  ○ Unexplained iron deficiency with or without anaemia
	• Aged ≤ 39 years and recurrent, unexplained iron deficiency or positive FOBT (with or without gastrointestinal symptoms)
	• Any age and serology suggestive of coeliac disease (new or uncontrolled)

Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≤ 39 years and single episode unexplained iron deficiency and negative FOBT (with or without gastrointestinal symptoms)

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration
- Provisional diagnosis

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Non-steroidal anti-inflammatory use
    - Weight loss (amount and timeframe)
    - Any previously received iron therapy (duration and timing)
    - Family history of gastrointestinal cancer or coeliac disease
    - Dietary history, including red meat intake
    - Menstrual history, familial haemoglobinopathies, blood donations
    - Full blood count
    - Haematinics (iron studies, red blood cell count, folate, vitamin B12)
    - Coeliac serology (total immunoglobulin A (IgA), tissue transglutaminase (tTG) with or without anti-endomysial antibody (EMA))

Additional information (if available)

- Faecal Occult Blood Test (FOBT) result
- Previous endoscopy or histology reports
- Electrolytes, urea and creatinine (EUC)
- Liver function test result
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Liver dysfunction (adult)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar. • Liver failure (bilirubin > 100, INR > 2.0) with clinical signs of decompensation	
Out of scope (not routinely provided)	
• Fatty liver with normal liver function tests and Fibrosis-4 (FIB 4) score below 1.3 (meaning no significant fibrosis evident)	
Access and prioritisation	

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Abnormal liver function tests if any of the following:
	  ○ Bilirubin > 34
	  ○ Albumin < 35
	  ○ INR > 1.7 and/or platelets are outside normal range in setting of known or suspected liver disease (excluding unconjugated hyperbilirubinemia)
	• Abnormal liver function tests associated with new symptoms (e.g. nausea, anorexia), or ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months
	• Persisting liver inflammation with ALT > 200 for more than a month
	• New, abnormal liver function in a pregnant patient

Category 2 (clinically recommended to be seen within 90 calendar days)	• Liver disease treatment required where outside the referrer scope of practice (e.g. viral hepatitis, haemochromatosis, autoimmune liver disease, primary sclerosing cholangitis, primary biliary cholangitis, Wilson's disease) • Metabolic syndrome or alcohol dependence suspected and non-invasive serological algorithm (Fibrosis-4 (FIB 4)) suggestive of cirrhosis (FIB 4 score above 3.5; a threshold where cirrhosis is likely), or elastography or radiologic evidence of cirrhosis
Category 3 (clinically recommended to be seen within 365 calendar days)	• Metabolic syndrome associated liver function tests (LFT) derangement suspected (MAFLD) and fibrosis indeterminate (FIB 4 score 1.3 – 3.5) where significant fibrosis and even cirrhosis is possible • Abnormal LFTs and negative liver screen regardless of aetiology, severity or degree of work-up performed • Fibrosis assessment requested (Fibroscan referral) when FIB 4 score above 1.3 (indeterminate), or known or risk factors for chronic liver disease requiring monitoring

	(e.g. methotrexate, metabolic associated steatohepatitis, Hepatitis B)

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Alcohol intake (duration and quantity)
    - Risk factors for viral hepatitis
    - Full blood count or coagulation profile
    - HbA1c
    - Iron studies
    - Hepatitis A serology (HAV IgG)
    - Hepatitis B serology (HBV sAg, sAb, cAb, and if HbsAg+, HBeAg/Ab and HBV DNA)
    - Hepatitis C serology (HCV Ab, and if Ab+, HCV RNA)
    - Liver function test results (current and previous)
    - Upper abdomen ultrasound

Additional information (if available)

- Previous ultrasound, CT or MRI reports
- Elastography or other liver imaging
- Vaccination history
- Any relevant family history
- Additional pathology tests (e.g. autoimmune hepatitis, primary biliary cirrhosis, Wilson's disease, genetic disorders)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Upper gastrointestinal dysfunction (adult)

Emergency	
If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar. • Dysphagia with inability to tolerate oral intake	
Out of scope (not routinely provided)	
• Belching • Halitosis	
Access and prioritisation	

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Dysphagia any age or symptoms (excluding longstanding)
	• Dyspepsia, heartburn or reflux with any of the following present:
	  ○ Warning symptoms:
	  - Haematemesis or melaena
	  - ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months
	  ○ Laboratory indicators:
	  - Iron deficiency
	  - Anaemia
	  - Low albumin
	• Abnormal imaging of the upper gastrointestinal tract suggesting space occupying lesion

Category 2 (clinically recommended to be seen within 90 calendar days)	• Helicobacter eradication failed (urea breath test) after standard first line therapy (7-14 days triple esomeprazole, clarithromycin, amoxicillin or metronidazole) • Aged ≥ 50 years with new, unexplained or persistent dyspepsia symptoms despite proton pump inhibitors
Category 3 (clinically recommended to be seen within 365 calendar days)	• Aged ≤ 49 years with longstanding, unexplained or persistent dyspepsia despite proton pump inhibitors • Screening for Barrett's oesophagus in patients with longstanding gastroesophageal reflux without additional symptoms • Surveillance of known Barrett's oesophagus • Surveillance for gastric cancer in patients with history of intestinal metaplasia

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Family history of gastrointestinal cancers
    - Weight loss (amount and timeframe)
    - Medical management to date (e.g. proton pump inhibitors, *Helicobacter pylori* treatment)
    - Smoking history
    - Full blood count
    - Iron studies

Additional information (if available)

- Previous endoscopy or histopathology results
- Relevant imaging reports
- *Helicobacter pylori* results, including urea breath tests
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)