NSW Health

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 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 the following presenting conditions:

- Concern for colorectal cancer (Rectal bleeding or Positive Faecal Occult Blood Test) (adult)
- Iron deficiency (adult)
- Hepatocellular cancer (suspected or known) or liver lesion (adult)
- Inflammatory bowel disease or irritable bowel syndrome (suspected or known) (adult)
- Liver dysfunction (adult)
- Cirrhosis (suspected or known) (adult)
- Upper gastrointestinal dysfunction (adult)

Notes

- Gastroenterology SRC are applicable to NSW Local Health Districts and Specialty Health Networks with existing public gastroenterology and applicable allied health-led, nurse-led or medical/surgical-led outpatient services that manage the identified presenting conditions
- Gastroenterology SRC are applicable where the identified presenting conditions managed by gastroenterologists and surgeons are delivered in private practice as part of public-private hospital arrangements
- 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 or medical/surgical-led outpatient services, however some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local context
- 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 sets thresholds for referral to NSW public gastroenterology and applicable allied health-led, nurse-led or medical/surgical-led outpatient services, and the expected clinical urgency category based on clinical need

Acknowledgements

NSW Health would like to extend its appreciation to all clinicians, administrators and consumers who contributed to the development of Gastroenterology SRC for NSW public specialist outpatient services. NSW Health would also like to acknowledge the SRC developed by QLD Health, VIC Health, SA Health and WA Health which has been referenced to support the development of Gastroenterology SRC for NSW public specialist outpatient services.

Significant contributors: Dr Miriam Levy (Clinical Lead), Dr Ian Norton, Dr Golo Ahlenstiel, Dr Steven Bollipo, Dr Tim Walker, Dr Peter Lim, Dr Ted Stoklosa, Dr Aravind Suppiah, Mark Costello, Kylie Bennetts, Kristine Dimagmaliw, Nicole Getreu, Dr Luke Morphett, Dr Daniel Ewald, Dr Ai-Vee Chua, Dr Anju Aggarwal, Dr Rowena Ivers, Dr Neil Merrett

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 / 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
Referral requirements	• 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
Other content	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria may support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

Gastroenterological emergencies

Note: this emergency criteria are not an exhaustive list of gastroenterological emergencies. Please refer to HealthPathways for more information.

Presenting condition
Acute surgical syndrome suspected by: • **Presence of shock or sepsis and abdominal pain (e.g. peritonitis, appendicitis cholecystitis, cholangitis, severe diverticulitis, gut infarction or bowel obstruction, incarcerated hernia)** • **Ruptured abdominal aortic aneurysm (AAA)** • **Ectopic pregnancy** • **Ovarian torsion** • **Testicular torsion** • **Urosepsis** • **Gynaecological sepsis** • **Bowel obstruction** • **Acute pancreatitis**
Acute, severe colitis (e.g. Crohn's disease, ulcerative colitis or infectious) ≥ 6 bloody bowel stools per 24 hours (Truelove and Witts criteria) 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**
Melaena or haematochezia, haematemesis or vomiting in large volume or with haemodynamic compromise
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
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: patients with > 6 bloody bowel motions per 24 hours plus 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)**
Gastrostomy feeding tube problems with blocked or displaced gastrostomy in patients with nil oral route for nutrition or hydration
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
Cholangitis (pain, fever and jaundice)
Dysphagia with inability to tolerate oral intake

Out of scope / Not routinely provided

Presenting condition
Abdominal pain – second opinions for conditions already seen by the same specialty
Hepatocellular cancer surveillance, when indicated to be conducted in a primary care setting *(see Cancer Council guidelines for more information)*
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
Haemorrhoid surgery or banding (if medical therapy fails) Note: referral to colorectal surgery is indicated
Fissure surgery (if medical therapy fails) Note: referral to colorectal surgery is indicated
Persistent but unchanged gastrointestinal symptoms previously investigated
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.
Fatty liver with normal liver function tests and Fibrosis-4 (FIB 4) score below 1.3 (meaning no significant fibrosis evident)
Belching
Halitosis

Presenting Conditions

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/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 • Haemorrhoid surgery or banding (if medical therapy fails) Note: referral to colorectal surgery is indicated • Fissure surgery (if medical therapy fails) Note: referral to colorectal surgery is indicated • Persistent but unchanged gastrointestinal symptoms previously investigated	
Access / 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 (age for colonoscopy depends on syndrome) ○ Suggestive of a moderate or high-risk colon cancer *(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)

Referral requirements

- Patient and family history of gastrointestinal cancer, including age of diagnosis
- Documented duration and associated symptoms
- Weight loss (amount and timeframe)
- Full blood count
- Haematinics (iron studies, red blood cell count, folate, vitamin B12)
- Patient health summary (including relevant medical history and medications)

Other content

- 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’ and/or among a vulnerable, disadvantaged or priority population

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/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 / 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)

Referral requirements

- Duration of symptoms
- Any previously received iron therapy (duration and timing)
- Menstrual history, familial haemoglobinopathies, blood donations
- Family history of gastrointestinal cancer or coeliac disease

- Dietary history, including red meat intake
- Weight loss (amount and timeframe)
- Non-steroidal anti-inflammatory use
- Full blood count
- Haematinics (iron studies, red blood cell count, folate, vitamin B12)
- Coeliac serology (total immunoglobulin A (IgA), tissue transglutaminase (tTG) +/- anti-endomysial antibody (EMA))
- Patient health summary (including relevant medical history and medications)

Other content

- 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’ and/or among a vulnerable, disadvantaged or priority population

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/registrar.

- Nil

Out of scope / not routinely provided

- Nil

Access / 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

Referral requirements

- Liver imaging result (current and any previous)
- Full blood count
- Tumour markers (alpha feto-protein (AFP), carbohydrate antigen 19-9 (Ca 19-9), carcinoembryonic antigen (CEA))
- Coagulation profile test result
- Liver function test result
- Renal function test result
- Patient health summary (including relevant medical history and medications)

Other content

- 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’ and/or among a vulnerable, disadvantaged or priority population

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/registrar.

- 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
- 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)

Out of scope / not routinely provided

- Nil

Access / 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 cholangitis colitis, faecal incontinence) and seeking specialist advice

Referral requirements

- Results of stool MCS, ova, cysts and parasites, *Clostridioides difficile* toxin
- Molecular testing of stool for infection
- Personal or family history of inflammatory bowel disease
- Full blood count
- Faecal calprotectin result
- Liver function test result
- Electrolytes, urea and creatinine (EUC)
- Iron studies
- C-reactive protein (CRP)
- Relevant imaging reports
- Current and previous colonoscopy results
- Smoking history
- Patient health summary (including relevant medical history and medications)

Other content

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

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/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 / 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)

Referral requirements

- Liver function test results (current and previous)
- Full blood count or coagulation profile
- Upper abdomen ultrasound
- 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
- HbA1c
- Alcohol intake (duration and quantity)
- Risk factors for viral hepatitis
- Patient health summary (including relevant medical history and medications)

Other content

- 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' and/or among a vulnerable, disadvantaged or priority population

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/registrar. • 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 • Cholangitis (pain, fever and jaundice)	
Out of scope / not routinely provided	
• Nil	
Access / 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 bloods, 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) *(patients with stable compensated who only require hepatocellular cancer surveillance may be appropriately managed in general practice)*

Referral requirements

- Alcohol intake
- Risk factors for viral hepatitis
- Current and previous liver function tests
- Full blood count or coagulation profile
- Upper abdomen ultrasound
- 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
- Patient health summary (including relevant medical history and medications)

Other content

- HbA1c
- 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’ and/or among a vulnerable, disadvantaged or priority population

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/registrar. • Dysphagia with inability to tolerate oral intake	
Out of scope / not routinely provided	
• Belching • Halitosis	
Access / 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

Referral requirements

- Family history of gastrointestinal cancers
- History of weight loss
- Duration of symptoms
- Medical management to date (e.g. proton pump inhibitors, *Helicobacter pylori* treatment)
- Full blood count
- Iron studies
- Smoking history
- Patient health summary (including relevant medical history and medications)

Other content

- 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' and/or among a vulnerable, disadvantaged or priority population