REFERRAL GUIDE

Respiratory and Sleep

Respiratory and sleep clinic specialises in the diagnosis and management of all respiratory and sleep disorders

Clinical Lead

Dr Suzy Guo

Respiratory & Sleep Physician

Suzy.Guo@basscoasthealth.org.au

How to Refer

All new referrals for Specialist Outpatient Clinics require a **medical referral.**

All new referrals are processed by the BCH Access Department.

The **preferred mode** for external referrals to the Access Department is Fax (03) 9102 5307.

Internal referrals from within Bass Coast Health can be sent via email (Access@basscoasthealth.org.au)

For further information on new referrals and services provided via the BCH Access Team on (03) 5671 3175 or by email to Access@basscoasthealth.org.au

Relevant referral form

Outpatient specialist clinic referral (MR-309)

Referrer guidance

Clinically recommended guidance for referrers is available through Gippsland Pathways.

Eligibility

Prior to referral, please check and ensure all referrals for Specialist Outpatient Clinics **meet;**

- Minimal Referral Criteria
- State-wide Referral Criteria (where applicable),
- Obstructive Sleep Apnoea (OSA) Assessment - Questionnaires are a referral requirement for Adult Sleep disorders
  - OSA - Epworth Sleepiness Scale (ESS)
  - OSA - OSA50
  - OSA - STOP-Bang
- Local BCH service eligibility

Please note, the Managing referrals to non-admitted specialist services policy states that we must not accept referrals that are incomplete or do not have the required information to assess.

Once we receive a referral we will **review to ensure**:

- We have all the information we need to progress
- The referral meets the Minimum referral criteria, State-wide Referral Criteria (where applicable) as well as local BCH service eligibility
- Identify the best service/s to meet your patients' needs and
- Assign a referral priority, urgent or routine
- Provide a notification of a referral outcome

Referral Processing

Accepted referrals are **triaged according to priority** by our specialist doctors/health professionals, as 'urgent' or 'routine'.

High priority, 'urgent' access, is assigned to patients that have a condition with potential to deteriorate quickly, with significant consequences for health and quality of life if not managed promptly.

For **urgent referrals**, we will contact the patient and aim to schedule an appointment within 30 days or at the earliest available time.

For **routine referrals**, we will notify you and the patient of a routine appointment date or the transfer onto a service waitlist and aim to schedule an initial appointment within 365 days.

Within 8 working days, we will aim to send you and your patient notification of the **referral outcome**, i.e. if the referral has been:

- Accepted and an appointment has been scheduled OR
- Accepted and the patient has been placed on a service waiting list OR
- Not accepted and the reasons why

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Priority

EMERGENCY

Conditions requiring **immediate emergency care**. Acute referrals requiring same day assessment or admission. **Recommend or contact '000' to arrange immediate transfer to emergency.**

URGENT

Assigned to patients that have **a condition with potential to deteriorate quickly**, with significant consequences for health and quality of life if not managed promptly. Aim to **schedule an initial appointment within 30 days** or at the earliest available time.

ROUTINE

Assigned to patients when **their condition is unlikely to deteriorate quickly** or have significant consequences for health and quality of life if the specialist assessment is delayed beyond 30 days. Routine appointments are scheduled (where possible) or transferred onto a service waitlist. Aim to **schedule an initial appointment within 365 days**.

Safety risk screening

RED FLAG CONDITIONS

EMERGENCY

Red flags signal the most serious clinical risks and need for same day assessment or admission.

- Life threatening asthma, including thunderstorm asthma
- Acute moderate asthma not responding to GP management
- Acute severe asthma (via ambulance) e.g. coexistent pneumothorax or pneumonia, silent chest, cardiovascular compromise, altered consciousness, relative bradycardia or decreasing rate and depth of breathing
- Asthma with intercurrent disease e.g. Pneumonia
- Severe breathlessness, breathlessness at rest and oxygen saturation < 90 percent, or a reduction of 3 to 4 percent from usual baseline
- Worsening hypoxaemia
- Significant haemoptysis or difficult to control pain
- New arrhythmia or chest pain
- Soft or absent breath sounds, cyanosis, or poor respiratory effort
- COPD Acute exacerbations and Respiratory failure.
- Significant, new or changed respiratory symptoms (for example unable to eat, sleep or walk)
- Pleural Effusion with rapidly accumulating or significant symptomatology at rest
- All acute pneumothorax patients need emergency department assessment
- Rapid progression of Obstructive Sleep Apnoea

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Procedures/Conditions seen at Bass Coast Health

- Asthma
- Bronchiectasis
- Chronic obstructive pulmonary disease (COPD)
- Cough (persistent)
- Interstitial lung disease (ILD)
- Lung Cancer
- Pleural Effusion
- Pneumonia
- Pneumothorax
- Unexplained chronic breathlessness
- Adult sleep disorders

Exclusions

The following conditions / procedures are not routinely seen at Bass Coast Health

- Pulmonary Function Tests
- Home Oxygen Assessments
- Patients who have purchased their CPAP machine from an external supplier experiencing technical problems

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Asthma

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

- Previously diagnosed asthma that requires further advice on, or review of, the current management plan or management of treatment related adverse effects
- Asthma with clinical or spirometry features suggestive of an alternative or additional diagnosis
- Asthma caused or exacerbated by workplace exposure that is impacting on the person's ability to work

Additional Information to be included

Patient history:

- Description of onset, nature, progression, recurrence and duration of symptoms (e.g. Breathlessness, tightness, wheezing and cough)
- Recognition of severity
- Any known or suspected allergies or triggers
- Age at diagnosis
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Spirometry with bronchodilator reversibility
- Recent FBE (last 6 months)
- Immunoglobulin E (IgE)

EMERGENCY

- Life threatening asthma, including thunderstorm asthma (after initial emergency management)
- Severe asthma, including thunderstorm asthma, if symptoms have not resolved after initial emergency management
- Oxygen saturation < 90%
- Soft or absent breath sounds, cyanosis, or poor respiratory effort
- Bradycardia or hypotension
- Exhaustion, confusion, or coma.

URGENT

- Brittle asthma: Severe or difficult to treat asthma requiring frequent hospitalisations with irregular peak flows despite high doses of steroids

ROUTINE

See: When to refer criteria

- Asthma not readily controlled in GP setting
- Frequent after-hours attendance (ED or GP after hours service)
- Asthma with additional lung disease (e.g. Bronchiectasis, COPD)
- Oral prednisolone requirements in community

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Bronchiectasis

State-wide Referral Criteria **DOES NOT** apply to this condition.

When to refer

- Suspected Bronchiectasis

Should be considered in those with chronic or recurrent purulent sputum. Quantitate phlegm production when well and when ill

or

- Previously diagnosed Bronchiectasis requiring advice on, or review of, the current management plan or management of treatment related adverse effects

Additional Information to be included

Patient history:

- Onset, nature and duration of symptoms of Bronchiectasis (e.g. persistent, productive cough, sputum load, breathlessness, etc.)
- Impact of symptoms on exercise tolerance, functional capacity (ALDs)
- Past history of severe respiratory infection usually in childhood e.g. Whooping Cough.
- History of Asthma
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Spirometry with bronchodilator reversibility
- Chest X-ray
- High resolution CT (HRCT) Lungs (Not during an exacerbation)
- Recent Full Blood Count,
- Erythrocyte sedimentation rate (ESR)
- Sputum culture when patient otherwise well and with exacerbations
- Assessment for sinus disease

EMERGENCY

- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- Specialist assessment and management required for patients suspected of having Bronchiectasis
- All referrals for Bronchiectasis considered routine

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Chronic obstructive pulmonary disease (COPD)

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

- Assessment for difficult to control symptoms or unusual symptoms such as haemoptysis or dysfunctional breathing, where lung cancer or other critical respiratory illness has been excluded
- Assessment for uncertain diagnosis
    - bullous lung disease
    - COPD patient age < 40
    - onset of right-sided heart failure
    - exclusion of asthma
    - frequent chest infections
- Advice on, or review of, the management of moderate or severe COPD or COPD with rapid decline in forced expiratory volume

Additional Information to be included

Patient history:

- Onset, nature and duration of symptoms and breathlessness
- Impact on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Cough and sputum
- R) heart failure
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if still using
- Past medical history and comorbidities
- Consider common co-morbidities: anxiety, depression, cardiovascular, osteoporosis

Investigations:

- Spirometry, reversibility, gas transfer
- Chest X-Ray (including date and details of the diagnostic imaging practice)
- FBE (last 6/12)
- Sputum culture
- Urea and electrolyte results (last 6/12)

EMERGENCY

- Significant, new or changed respiratory symptoms (for example unable to eat, sleep or walk)
- Breathlessness at rest and oxygen saturation < 90 percent, or a reduction of 3 to 4 percent from usual baseline
- Sudden or severe worsening of symptoms (e.g. breathlessness, cough)
- Acute confusion or impaired consciousness.

URGENT

- Patients with diagnosed COPD requiring home oxygen consultation (home oxygen assessment completed)

*N.B. Home oxygen assessment – currently not completed at BCH

ROUTINE

- Patients with high symptom burden
- Frequent exacerbations
- Right heart failure/pulmonary hypertension

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Cough (persistent)

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

Persistent cough (> 8 weeks) with normal chest x-ray and normal pulmonary function and where any of the following explanations have already been excluded:

- asthma
- chronic obstructive pulmonary disease (COPD)
- chronic rhinosinusitis
- gastroesophageal reflux
- hoarse voice (dysphonia)
- hypersensitivity or sensitivity to environmental irritants (e.g. perfumes and bleaches)
- lung cancer
- medicine induced cough (e.g. ACE-inhibitors, angiotensin-II receptor antagonist)
- respiratory infection
- smoking (cigarettes and all forms of tobacco, nicotine, vaping and cannabis).

Additional Information to be included

Patient history:

- Symptoms including duration, severity, any diurnal variation and associated syncope and incontinence
- How symptoms are impacting on activities of daily living including impact on work, study or carer role
- Findings on physical examination, including oxygen saturation
- Details of previous management including the course of treatment(s) and outcome of treatment(s)
- Any known or suspected allergies or triggers
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest x-ray (including date and details of the diagnostic imaging practice)
- Recent FBE (last 6 months)
- Erythrocyte sedimentation rate (ESR)

ROUTINE

- All referrals for persistent cough consultation are considered routine

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Interstitial lung disease (ILD)

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

- Suspected or confirmed interstitial lung disease that requires further advice on, or review of, the current management plan, or management of treatment related adverse effects (e.g. dyspnoea associated with chest pain or palpitations, stridor, significant hypoxaemia, unintended weight loss)
- Confirmation of suspected diagnosis and advice on management plan.

Additional Information to be included

Patient history:

- Onset, nature progression, recurrence and duration of symptoms of ILD
- Impact of symptoms on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest X-Ray (including date and details of the diagnostic imaging practice)
- Recent FBE (last 6/12)

EMERGENCY

- severe breathlessness
- worsening hypoxaemia
- new arrhythmia or chest pain.

Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- All referrals for ILD consultation are considered routine

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Lung Cancer

State-wide Referral Criteria **DOES NOT** apply to this condition.

When to refer

Confirmation of Lung Cancer /Mesothelioma diagnosis and requires advice on, or review of, the current management plan, or management of treatment related adverse effects.

Additional Information to be included

Patient history:

- Onset, nature and duration of any symptoms (e.g. persistent cough, shortness of breath, chest pain, weight loss, and systemic symptoms)
- N.B. Patient can be asymptomatic
- Impact of symptoms on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- CT Chest **MUST** be completed/reported prior to referral

EMERGENCY

- Refer to Safety Risk Screening – Red Flag Conditions

URGENT

- New malignancy (with an accompanying CT report)
- All referrals for newly diagnosed malignancy are considered urgent

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Pleural Effusion

State-wide Referral Criteria **DOES NOT** apply to this condition.

When to refer

Previously diagnosed Pleural Effusion and requires advice on, or review of, the current management plan, or management of treatment related adverse effects.

Additional Information to be included

Patient history:

- Onset, nature and duration of any symptoms e.g. Breathlessness, symptoms and signs of underlying condition e.g. heart failure, neoplasia and infection
- Impact on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest x-ray
- Full Blood Examination (FBE)
- Lactate Dehydrogenase (LDH)
- Total protein tests
- Liver function tests (LFTs)

Consider:

- Echocardiogram if cardiac history or cardiac symptoms
- CT chest if features of malignancy or infection.

EMERGENCY

** All symptomatic large pleural effusion- should be redirected to ED.

- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- Recurrent pleural effusions with malignancy ruled out

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Pneumonia

State-wide Referral Criteria **DOES NOT** apply to this condition.

When to refer

Previous diagnosis of Pneumonia that requires advice on, or review of, the current management plan or management of treatment related adverse effects

Additional Information to be included

Patient history:

- Onset, nature progression, recurrence and duration of symptoms
- Impact of symptoms on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest X-Ray (including date and details of the diagnostic imaging practice)
- Recent FBE (last 6/12)

EMERGENCY

- severe breathlessness or
- worsening hypoxaemia or
- new arrhythmia or chest pain.

to be directed to ED

- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- Recurrent/resolved pneumonia with other respiratory condition diagnosis

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Pneumothorax

State-wide Referral Criteria **DOES NOT** apply to this condition.

When to refer

- Previously diagnosed and managed non-acute pneumothoraxes
- Recurrent pneumothoraxes

that require advice on management plan, management of treatment adverse reactions

Additional Information to be included

Patient history:

- Onset, nature progression, recurrence and duration of symptoms (e.g. pain, breathlessness)
- Impact of symptoms on exercise tolerance, functional capacity (ALDs)
- Findings on physical examination, including oxygen saturation
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest X-Ray (including date and details of the diagnostic imaging practice)
- Recent FBE (last 6/12)

EMERGENCY

** All patients with suspected or confirmed acute pneumothorax to be directed to ED

- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- Recurrent pneumothoraxes (treated)

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Unexplained chronic breathlessness

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

Unexplained chronic pathological breathlessness where any of the following explanations have **already been excluded**:

- anaemia
- anxiety or hyperventilation
- cardiac conditions (e.g. congestive cardiac failure, ischaemic heart disease, cardiac arrhythmias, myocardial infarct)
- occupational exposure
- respiratory conditions (e.g. chronic obstructive pulmonary disease (COPD), interstitial lung disease, lung malignancy, upper airway obstruction)
- smoking (cigarettes and all forms of tobacco, nicotine, vaping and cannabis) or inhalant use
- thyroid disease.

Additional Information to be included

Patient history:

- Symptoms including duration, severity and any diurnal variation
- How symptoms are impacting on activities of daily living including impact on work, study or carer role
- Findings on physical examination, including oxygen saturation
- Weight
- Any known or suspected allergies or triggers
- Smoking history (if relevant)
- At risk occupational history (if relevant)
- Current and complete medication history
- History of any other inhalant use, including if the patient is still using
- Past medical history and comorbidities

Investigations:

- Chest x-ray (including date and details of the diagnostic imaging practice)
- Recent FBE (last 6 months)

EMERGENCY

- severe breathlessness or
- worsening hypoxaemia or
- new arrhythmia or chest pain.

to be directed to ED

- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- All referrals for referrals for unexplained chronic breathlessness consultation are considered routine

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Adult sleep disorders

State-wide Referral Criteria **DOES** apply to this condition.

When to refer

- Symptomatic patients with a high probability for moderate to severe obstructive sleep apnoea based on Epworth Sleepiness Score (ESS) and a high probability for moderate to severe obstructive sleep apnoea based on a STOP-Bang score or OSA50 score
- Patients with new, or worsening, sleep issues unresponsive to current medical management that require further advice on sleep management
- Driving assessments
- Requests for sleep studies for patients that are ineligible for, or unable to access, a General Practitioner (GP) requested sleep study.

Additional Information to be included

- Description of onset, nature, progression, recurrence and duration of symptoms (somnolence, snoring, witnessed apnoea, restless sleep, unrefreshing sleep, tiredness)
- How these symptoms are impacting on activities of daily living including impact on work, study, school or carer role and level of sleep disturbance
- Occupation
- Completed Epworth Sleepiness Score (ESS)
- Completed STOP-Bang score or OSA50 score
- Body mass index (BMI)
- Level of alcohol intake
- Smoking history (cigarettes and all forms of tobacco, nicotine, vaping and cannabis)
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Past medical history and comorbidities.
- CPAP efficacy data if already has a prescribed CPAP machine

EMERGENCY

- Rapid Progression of Obstructive Sleep Apnoea
- Refer to Safety Risk Screening – Red Flag Conditions

ROUTINE

- All referrals for Adult Sleep disorders are considered routine