

# GP Referral Criteria

## 2010 Edition

- Princess Alexandra Hospital
- QEII Jubilee Hospital
- Logan Hospital
- Redland Hospital



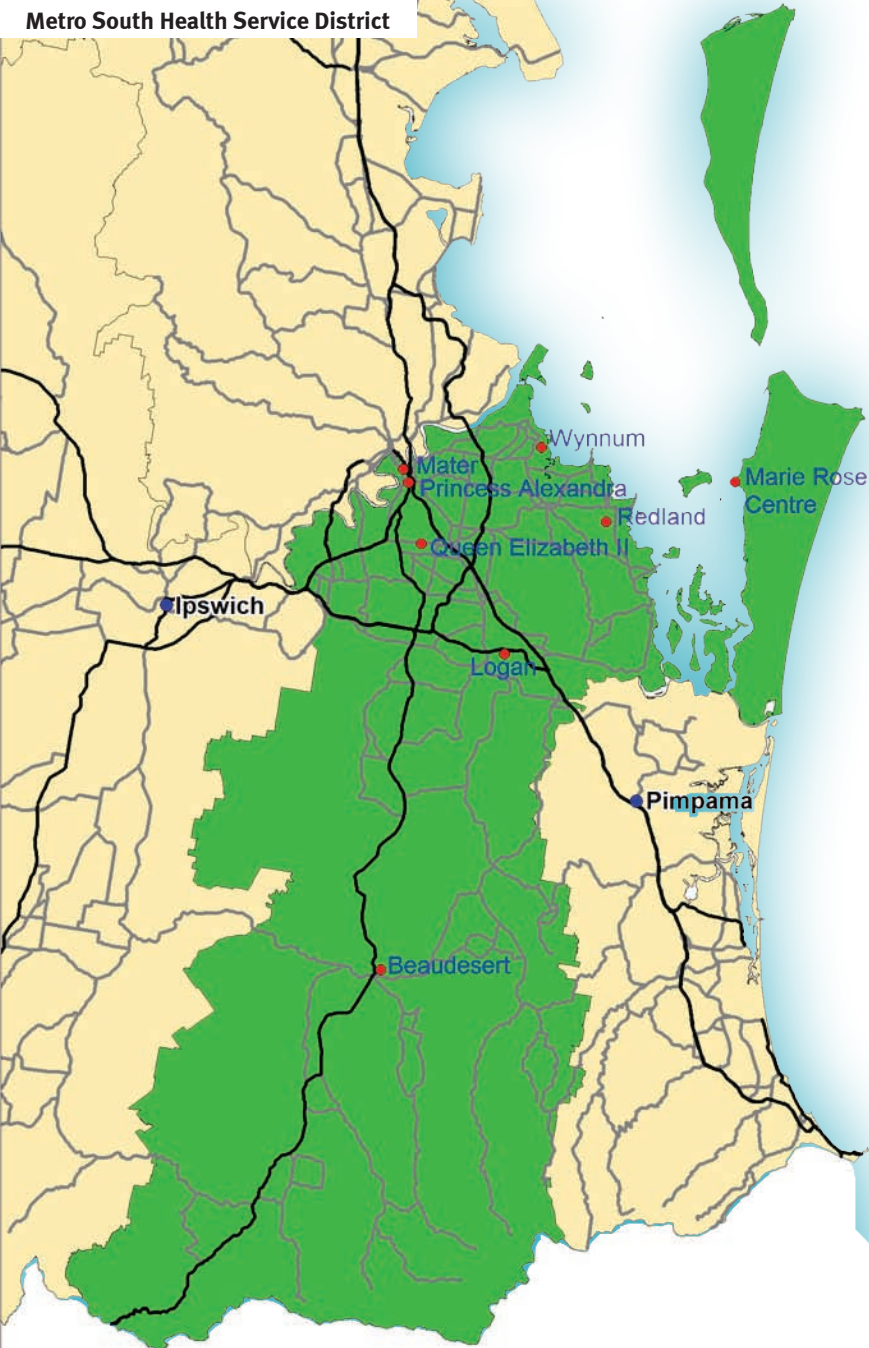
**Metro South GP Referral Criteria - Version 6.0 - February 2010**

*Printed copies are uncontrolled*

An updated version of this information is available on the following Queensland Health website:

**<http://www.health.qld.gov.au/metrosouth>**

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With acknowledgement and thanks to Metro South facilities, General Practice Queensland, South East Primary Health Care Network, South East Alliance of General Practice, Brisbane South Division of General Practice, Logan GP Integration Program and Princess Alexandra Hospital Multi Media Unit.



# Welcome

This booklet contains a comprehensive list of public outpatient clinics provided at the following hospitals within Queensland Health's Metro South Health Service District:

- Princess Alexandra Hospital
- QEII Jubilee Hospital
- Logan Hospital
- Redland Hospital

The contact details, referral criteria, and patient notes for each specialty are included to assist you and your patients in accessing our services.

A fully updated version of the information contained in this booklet is available online at: [www.health.qld.gov.au/metrosouth](http://www.health.qld.gov.au/metrosouth).

In addition, our hospitals now offer private (bulk billed) services in many existing outpatient clinics. Please see page 3 for more information.

Should you require further assistance, please contact the relevant outpatient clinic via the telephone number listed in this guide.

## Questions or concerns?

If you have any concerns about the outcome of your referral, or your patients's health status has changed, please contact the relevant specialty outpatient department. Contact numbers are included in this guide.

# General Referral Criteria

Referrals to specialist outpatient services in Metro South Health Service District must be in writing, and as a minimum contain the following:

- Patient demographics including Medicare number and Interpreter requirements
- Patient's mobile phone contact number and an alternate postal or contact address (if not the same as usual residence)
- Reason for referral (including the problem to be assessed, degree of loss of function, pain experienced)
- Results of relevant investigations (pathology, radiology, histology)
- Current medications and doses, prescribed and over the counter (Note any recent changes in drug therapy)
- Allergies (drug/topical preparation)
- Relevant information about the patient's condition such as previous medical/surgical treatment (include systemic and topical medications prescribed for the condition) and details of any associated medical conditions which may affect the condition or its treatment (e.g. Diabetes)
- Relevant psychological and social issues impacted by condition
- Smoking and alcohol history

Inclusion of this information will assist in a thorough assessment of the referral and ensure appropriate future appointment scheduling.

## Where to send your referral

**Fax:** Please fax the referral using the appropriate number listed in this guide.

**Post:** Please post the referral directly to the outpatient clinic using the appropriate address below:

### PAH

*(insert clinic name)*  
Outpatient Bookings  
Princess Alexandra Hospital  
Ipswich Road  
Woolloongabba QLD 4102

### QEII

*(insert clinic name)*  
Outpatient Bookings  
QEII Jubilee Hospital  
Locked Bag 2  
Archerfield QLD 4108

### Logan

*(insert clinic name)*  
Outpatient Bookings  
Logan Hospital  
PO Box 4096  
Loganholme DC QLD 4129

### Redland

*(insert clinic name)*  
Outpatient Bookings  
Redland Hospital  
PO Box 585  
Cleveland QLD 4163

# Bulk Billed Clinics

Queensland Health's public hospitals now offer private (bulk billed) services in many existing outpatient clinics. This means that your patient has the right to choose to be treated as a private patient within any facility listed in this guide and can be bulk billed for the service with no gap.

These funds will allow for the delivery of improved clinical services to the local community and your patients.

If seen as a bulk billed (private) patient, the benefits will be that:

- your patients will have access to one of our staff specialists with right of private practice, and
- the consultation and investigations performed will be bulk billed.

## How to refer to a private (bulk billed) clinic

To refer your patient to a private (bulk billed) clinic, please address the referral to the relevant clinic listed in this guide, and include a **named referral** to one of our staff specialists with Right of Private Practice. Our website contains a full list of staff specialists with Right of Private Practice under the 'Private Patients' link:

[www.health.qld.gov.au/metrosouth](http://www.health.qld.gov.au/metrosouth)

## Further information

For further information about private (bulk billing) clinics, please contact:

**PAH**  
Private Practice  
Phone: (07) 3176 2721

**QEII**  
Private Practice  
Phone: (07) 3275 6392

**Logan**  
Private Practice  
Phone: (07) 3299 8590

**Redland**  
Private Practice  
Phone: (07) 3488 3524

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For a VERY URGENT outpatient appointment, please phone the relevant hospital switchboard and ask to speak to the Registrar of the relevant specialty.

**Switchboard Phone Numbers - PAH 07 3176 2111 QEII 07 3275 6111 Logan 07 3299 8899 Redland 07 3488 3111**

Patient must bring to all appointments:

MEDICARE and any CONCESSION Cards (Pension/Health Care/DVA/PBS Safety Net/ADF etc)

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Alcohol and Drug Assessment	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <p>Please Note: This clinic is not a pain clinic and does not run opioid (methadone, subutex, suboxone) replacement programs</p>	Ph 07 31765191 Fax 07 31767211	Ph 07 32756278 Fax 07 32756228	Ph 07 32908900	Ph 07 34884222
Allergy	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• FBC</li> <li>• Skin Testing</li> <li>• RAST results</li> <li>• IgE</li> </ul> <p>Patient with non specific rashes should be referred to dermatology clinic in the first instance Please note: This clinic does not assess patients with Chronic Fatigue syndrome</p>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A
Antenatal	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• LNMP, Gravida, Parity, , EDC</li> </ul> <p>Blood Tests:</p> <ul style="list-style-type: none"> <li>• FBC, HepB, HepC, HIV, Syphilis serology, Blood group and antibodies</li> <li>• Copy of morphology scan</li> </ul>	N/A	N/A	Ph 07 32998527 Fax 07 32998202	Ph 07 34883434 Fax 07 34883436

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Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Brain Injury Rehabilitation Assessment (acquired brain injury in the broad working age group)	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Include brain imaging</li> <li>• Broad working age group</li> <li>• Acquired brain injury</li> <li>• Allied health assessment (if available)</li> </ul>	Ph 07 31762520 Fax 07 31762900	N/A	N/A	N/A
Breast & Endocrine (Surgical)	<p><b>Please see General Surgery</b>  <b>For PAH only: For proven breast cancer, referrals should be directed to Cancer Services referral management (phone 3176 6199 or fax 3176 2670).</b></p>				
<p><b>Cancer Services</b></p> <ul style="list-style-type: none"> <li>• Clinical haematology (leukaemia, lymphoma, myeloma, stemcell transplant)</li> <li>• Medical Oncology</li> <li>• Radiation Oncology</li> <li>• Multidisiplinary clinics (colorectal, breast, upper GI, Melanoma, germ cell, brain)</li> <li>• Head and Neck Cancer (see ENT referral Requirments)</li> <li>• Lung Cancer (see Respiratory requirements)</li> <li>• Orthopaedic Cancer (see Orthopaedic requirements)</li> <li>• Brain Malignancy Clinic (see Neurosurgery requirements)</li> </ul>	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Please include any old pathology results which might help determine the duration/progression of a blood abnormality</li> <li>• Scan and xray results</li> <li>• Histology</li> <li>• Operative reports</li> </ul> <p>Medical oncology (do not refer undiagnosed cancer cases - refer to appropriate surgical or medical service).</p>	Ph 07 31766199 Fax 07 31762670	N/A	N/A	N/A
Cardiac Surgery	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Chest xray</li> <li>• U&amp;e's/LFT's</li> <li>• ECG</li> <li>• FBC</li> <li>• RFT's if indicated by long term smoking or chronic lung disease</li> </ul>	Ph 07 317626377 Fax 07 31766378	N/A	N/A	N/A

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Cardiac Surgery cont	<ul style="list-style-type: none"> <li>• Risk factors</li> <li>• Exercise tolerance</li> <li>• previous cardiological assessment data where performed, including formal echo angiogram disc either with referral or to PAH cath lab</li> </ul> <p><i>NB Patients with Valvular Heart Disease or suspected Coronary Artery Disease must have been assessed by a cardiologist prior to surgical referral</i></p>	Ph 07 317626377 Fax 07 31766378	N/A	N/A	N/A
Cardiology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• LFT, FBC, TFT, Cholesterol, Electrolytes</li> <li>• Exercise tolerance</li> <li>• results of any recent cardiac investigations if available (ECG, ECHO, Stress Test)</li> <li>• Chest xray</li> <li>• Risk factors</li> <li>• Significant symptoms eg: syncope, pre-syncope</li> </ul>	Ph 07 31766377 Fax 07 31766378	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Colorectal Surgery	<p><b>Please see General Surgery</b>  <b>For PAH only: For proven colorectal cancer, referrals should be directed to Cancer Services referral management (phone 3176 6199 or fax 3176 2670).</b></p>				
Colposcopy	<p><i>Please include Referral Criteria as listed on page 2, and,</i>            Copy of Pap smear (swabs if relevant)  <b>ALWAYS refer symptomatic patients regardless of pap test results</b></p>	N/A	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883420 07 34883421 Fax 07 34883588
Dermatology	<p><i>Please include Referral Criteria as listed on page 2.</i></p>	Ph 07 31762882 Fax 07 31767344	N/A	N/A	N/A

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Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Diabetes	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Type of diabetes and duration of disease</li> <li>Previous therapies that have been used to treat the disease</li> <li>Presence of any complications and details when screening last performed</li> <li>Previous allied health reviews Risk factors, Weight / BMI</li> <li>Blood pressure, History of smoking</li> <li>Whether patient has a GPMP/TCA in place</li> <li>HBA1c</li> <li>FBE, ELFTs, TFT, TSH</li> <li>Fasting Lipids – Chol, LDL, HDL, Tg</li> <li>Urinary protein / micro-albumin</li> </ul> <p>Additional tests if Type 1 Diabetes</p> <ul style="list-style-type: none"> <li>Anti-transglutaminase antibodies</li> </ul> <p>Additional tests if peripheral neuropathy</p> <ul style="list-style-type: none"> <li>B12, Folate, Serum EPP</li> </ul>	Ph 07 31761060 Fax 07 31761285	N/A	Ph 07 32998383 Fax 07 32999589	Ph 07 34883149 07 34883156 Fax 07 34883588
Endocrinology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Hormone levels</li> <li>Relevant investigations – any relevant imaging studies</li> <li>Pituitary Problem               <ul style="list-style-type: none"> <li>* Morning prolactin, LH, FSH, Oestradiol (testosterone if male), TSH, T4, Cortisol, ACTH, Growth hormone, IGF1, ELFT, FBE</li> </ul> </li> <li>Thyrotoxicosis               <ul style="list-style-type: none"> <li>* TSH, T4, T3, ESR, TSH receptor antibodies</li> </ul> </li> <li>Calcium disorder               <ul style="list-style-type: none"> <li>* ELFT, Ionised calcium, PTH, VitD and 1,25 (OH)<sub>2</sub> Vit D, 24 hour urine calcium</li> <li>* If primary hyperparathyroidism – Bone mineral density and US kidneys</li> </ul> </li> </ul>	Ph 07 31761060 Fax 07 31761285	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Endocrinology cont	<ul style="list-style-type: none"> <li>• Osteoporosis                             <ul style="list-style-type: none"> <li>* FBE, ELFT, ESR, Vitamin D, PTH, Ionised calcium, TSH, Serum EPP, anti-transglutaminase antibodies</li> <li>* Bone mineral density and vertebral xrays or xrays of fractures if relevant</li> </ul> </li> <li>• Adrenal insufficiency                             <ul style="list-style-type: none"> <li>* Short synacthen test, morning cortisol and ACTH, renin and aldosterone</li> </ul> </li> <li>• Cushing's syndrome                             <ul style="list-style-type: none"> <li>* 24 hour urine free cortisol, 1mg Dexamethasone suppression test, morning cortisol, ACTH</li> </ul> </li> <li>• Hypogonadism                             <ul style="list-style-type: none"> <li>* Morning LH, FSH, Oestradiol and progesterone (testosterone if male), prolactin</li> </ul> </li> </ul>	Ph 07 31761060 Fax 07 31761285	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
ENT Head & Neck Thyroid	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• CT</li> <li>• Audiology reports</li> <li>• Hearing Loss, Tinnitus, Vertigo, Unilateral Ear Symptoms.                             <ul style="list-style-type: none"> <li>* Audiology, pure tone audiogram (children &amp; adults)</li> </ul> </li> <li>• Sinusitis or Unilateral Sinus Pathology – adults                             <ul style="list-style-type: none"> <li>* CT Scan Paranasal Sinuses +/- contrast</li> </ul> </li> <li>• Cancer or Lump in Neck &gt; 4 weeks - adults                             <ul style="list-style-type: none"> <li>* Initially CT with contrast or USS of neck +/- FNA</li> </ul> </li> <li>• Routine bloods (FBC and film, ESR, U&amp;E's)</li> <li>• Nasal Fracture with cosmetic displacement                             <ul style="list-style-type: none"> <li>* Request appt within 5-7 days after injury to allow for surgery within 14 days, if required</li> </ul> </li> <li>• Head and Neck Skin Cancer                             <ul style="list-style-type: none"> <li>* Biopsy (punch) for histology</li> </ul> </li> </ul>	Ph 07 31766083 Fax 07 31762502	N/A	Ph 07 32998981 Fax 07 32998953	N/A

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Specialty	Referral Criteria	PAH	QEII	Logan	Redland
ENT Head & Neck Thyroid cont	<ul style="list-style-type: none"> <li>Dysphagia (adults)                             <ul style="list-style-type: none"> <li>* Barium swallow if symptoms indicate significant stenotic lesion</li> </ul> </li> <li>Thyroid                             <ul style="list-style-type: none"> <li>* TFT's</li> <li>* U/S +/- FNA</li> <li>* FBC, Ca+</li> </ul> </li> </ul>				
Gastroenterology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Presence or absence of alarm symptoms in patients with upper abdominal symptoms</li> <li>Family history of colo-rectal neoplasia in patients with lower abdominal symptoms</li> <li>E/LFT's, FBC &amp; ESR or CRP (all patients)</li> <li>Abdominal pain – Imaging US or CT</li> <li>Dyspepsia – H.pylori testing (breath test or stool antigen)</li> <li>Anaemia – Iron studies, B12, Folate</li> <li>Diarrhoea – Stool M/C/S, O/C/P, C difficile toxin, – coeliac serology</li> <li>results of any scopes undertaken</li> </ul>	Ph 07 31766530 Fax 07 31765111	Ph 07 32756278 Fax 07 327 6228	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
General Surgical <ul style="list-style-type: none"> <li>Breast &amp; Endocrine</li> <li>Colorectal</li> <li>General</li> <li>Hepatobiliary</li> <li>Upper GI</li> </ul>	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Please include sub-specialty</li> <li>Imaging (films &amp; reports)</li> </ul>	Ph 07 31765900 Fax 07 31767474  <b>For proven breast cancer, colorectal cancer, upper gastrointestinal cancer and melanoma, referrals should be directed to Cancer Services Referral Management (phone 3176 6199 or fax 3176 2670).</b>	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883420 07 34883421 Fax 07 34883588  <i>Patients &gt; than 12 yo General Surgery Only includes</i> <ul style="list-style-type: none"> <li>skin lesions</li> <li>hernia</li> <li>hydrocele</li> <li>gall bladder</li> <li>varicose veins</li> <li>haemorrhoids</li> <li>pilonidal sinus</li> </ul>

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Geriatric Medicine	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Community services currently in place</li> <li>• Current living arrangements</li> <li>• Home access issues</li> <li>• Name &amp; contact details of patients carer</li> <li>• CT Scan Films</li> <li>• Recent copies               <ul style="list-style-type: none"> <li>* FBE,E/LFT,B12,Folate,TSH,MSU</li> </ul> </li> <li>• <i>For Memory Clinic</i> <ul style="list-style-type: none"> <li>* Recent MMSE, CT brain, Carer contact details</li> </ul> </li> </ul> <p><b>Patients to bring to clinic</b></p> <ul style="list-style-type: none"> <li>• <b>All medications taken, Usual walking aid</b></li> <li>• <b>Usual foot wear, CT Scan Films</b></li> </ul>	Ph 07 31762520 Fax 07 31767387	Ph 07 32756541 Fax 07 32756525	N/A	Ph 07 34883149 07 34883156 Fax 07 34883588
Gynaecology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• <b>Post menopausal bleeding - mark as URGENT</b></li> <li>• Ovarian Cyst - Ultrasound               <ul style="list-style-type: none"> <li>&gt;35yrs. CA 125, CEA, CASA</li> <li>&lt;35yrs. hCG, AFP, LDH</li> </ul> </li> <li>• Menorrhagia-FBC, Ultrasound, TSH if signs &amp; symptoms of Thyroid disease</li> <li>• Postcoital bleeding/intermenstrual bleeding, pap smear, HVS, Chlamydia swab</li> <li>• Abnormal pap smear – refer to colposcopy clinic</li> <li>• Pelvic Pain – HVS, Swab for Chlamydia, Gonorrhoea &amp; Ultrasound</li> <li>• Prolapse – if stress incontinence present patient should be referred for 3 mths pelvic floor exercises, prior to referral</li> </ul>	N/A	Ph 07 32756403 Fax 07 32756529	Ph 07 32998981 Fax 07 32998953	Ph 07 34883420 07 34883421 Fax 07 34883588  <i>Greater than 12 y/o only</i>  <i>Excludes Essure, Reversal of Serilisation and Fertility issues</i>
Hepatology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Co-morbidities (current and past)               <ul style="list-style-type: none"> <li>* IDU, Alcohol Use,T2DM,BMI</li> <li>* Mental Health issues</li> </ul> </li> </ul>	Ph 07 31761058 Fax 07 31765111	N/A	N/A	N/A

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Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Hepatology cont	<ul style="list-style-type: none"> <li>• Vaccination status-to ascertain requirement for HAV, HBV, ADT etc</li> <li>• All patients               <ul style="list-style-type: none"> <li>* Abdominal ultrasound</li> <li>* ELFT-serial LFT's if available</li> <li>* FBC, PT</li> </ul> </li> <li>• Hepatitis C               <ul style="list-style-type: none"> <li>* HCV antibody, HCV RNA results, HCV genotype</li> </ul> </li> <li>• Hepatitis B               <ul style="list-style-type: none"> <li>* HBsAg, aHBs, aHBc</li> <li>* HbeAg, aHBe</li> <li>* HBV DNA</li> </ul> </li> <li>• Suspected Haemochromatosis               <ul style="list-style-type: none"> <li>* Iron studies</li> <li>* HFE gene studies</li> </ul> </li> <li>• Elevated LFT's               <ul style="list-style-type: none"> <li>* HCV &amp; HBV Antibody</li> </ul> </li> <li>• Suspected Liver Lesion               <ul style="list-style-type: none"> <li>* Abdominal imaging (preferably ultrasound)</li> </ul> </li> </ul> <p>Social circumstances which may influence patient outcomes, eg; unstable housing, unemployment or inability to work, management of ADL's, social support.</p>	Ph 07 31761058 Fax 07 31765111	N/A	N/A	N/A
Hypertension	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• BP recordings</li> </ul>	Ph 07 31762451 Fax 07 31762969 HYPT Nurse: 07 31765405 Urgent: 07 31762111 and ask for pager 931	N/A	N/A	Ph 07 34883149 07 34883156 Fax 07 34883588
Immunology	<p><i>Please include Referral Criteria as listed on page 2, and, If urgent review is required please contact the Immunology Registrar via the hospital switch board</i></p>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Infectious diseases	<i>Please include Referral Criteria as listed on page 2.</i>	Ph 07 31765920 Fax 07 31765540	Ph 07 32756278 Fax 07 32756228	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Internal Medicine	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>• List of names &amp; contact details of other health providers (including pharmacists, home &amp; community services) to whom the patient has been referred or from whom care is being received</li> <li>• copies of specialist letters/hospital discharge summaries/allied health evaluations or other correspondence relating to care received in the past from other health providers, either public or private, which are relevant to current referral</li> <li>• xray &amp; scan reports</li> </ul>	Ph 07 31765900 Fax 07 31767474	Ph 07 3275 6278 Fax 07 3275 6228	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 Fax 07 34883588
Melanoma	<b>For PAH only: For proven melanoma, referrals should be directed to Cancer Services referral management (phone 3176 6199 or fax 3176 2670).</b>				
Mental Health	<i>Please include Referral Criteria as listed on page 2.</i>	Ph 1300 858 998	Ph 1300 858 998	N/A	Ph 07 3488 3777
Maxillo-Facial	<i>Please include Referral Criteria as listed on page 2, and,</i> <p><b>Please remind patient to bring to appointment</b></p> <ul style="list-style-type: none"> <li>• Hard or electronic copies of radiology</li> <li>• Please include relevant microbiology/pathology and other investigations</li> <li>• Facial fractures <ul style="list-style-type: none"> <li>* CT Face</li> <li>* Contact registrar to arrange outpatient appointment review within 5-7 days</li> </ul> </li> <li>• Salivary glands <ul style="list-style-type: none"> <li>* Sialogram or US or CT as indicated</li> </ul> </li> <li>• Skin cancer (head/Neck/Face) <ul style="list-style-type: none"> <li>* Biopsy results</li> </ul> </li> <li>• Oral Cancer <ul style="list-style-type: none"> <li>* Biopsy results</li> </ul> </li> <li>• Facial deformity <ul style="list-style-type: none"> <li>* Plain skull films</li> </ul> </li> </ul>	Ph 07 31766083 Fax 07 31762502	N/A	Ph 07 32998981 07 32998672 Fax 07 32998953	N/A

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Specialty	Referral Criteria	PAH	QE II	Logan	Redland
Nephrology (General)	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• ELFT</li> <li>• FBC</li> <li>• MSU</li> <li>• Urine protein : creatinine ratio (albumin:creatinine ratio for diabetics)</li> <li>• Relevant scan reports</li> <li>• For transplant recipient – calcineurin inhibitor trough level (eg. Tacrolimus or cyclosporin level)</li> </ul>	Ph 07 31762615 Fax 07 31765480	N/A	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Neurology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Presence and duration of neurological symptoms</li> <li>• EEG</li> <li>• EMG</li> <li>• Xrays</li> <li>• Nerve conduction studies if relevant (all NCS referrals to PAH Neurology Department)</li> </ul>	Ph 07 31765900 Fax 07 31767474	Ph 07 3275 6278 Fax 07 3275 6228	Ph 07 32998981 07 32998672 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Neurosurgery	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Presence and duration of neurological sign and symptoms</li> <li>• Work status</li> <li>• Weight loss / appetite / lethargy</li> <li>• Fever and sweats</li> <li>• CT scan</li> <li>• Pituitary tumours: Hormone levels including: <ul style="list-style-type: none"> <li>Anterior pituitary function tests</li> <li>PRL</li> <li>Cortisol</li> <li>IGF1/GH</li> <li>T4</li> <li>FSH/LH</li> </ul> </li> </ul>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Neurosurgery cont	<ul style="list-style-type: none"> <li>• Treatment to date</li> <li>• History of malignant disease</li> <li>• General medical condition</li> <li>• Brain and Vascular disorders               <ul style="list-style-type: none"> <li>* note family history</li> <li>* CT</li> </ul> </li> <li>• Trigeminal neuralgia and other cranial nerve abnormalities               <ul style="list-style-type: none"> <li>* Provide details of severity of pain and other symptoms to assist in triage of appointment</li> <li>* Ability to eat/drink</li> <li>* Weight loss</li> <li>* Triggers</li> <li>* Maintain hygiene</li> <li>* CT</li> </ul> </li> <li>• Neck &amp; Back               <ul style="list-style-type: none"> <li>* Plain film and CT</li> <li>* FBC</li> <li>* ELFT</li> <li>* ESR</li> <li>* Rheumatoid serology in specific cases</li> </ul> </li> <li>• Peripheral Nerves               <ul style="list-style-type: none"> <li>* Nerve conduction studies (all NCS referrals to PAH Neurology Department)</li> </ul> </li> </ul>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A
Neurosurgery-Specialised Spinal Physiotherapy Screening (SSPC)	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• History and Management to date</li> </ul>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A
Ophthalmology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>• Past ocular history – trauma / operations</li> <li>• General medical history eg: Diabetes, Hypertension, Asthma</li> </ul>	Ph 07 31762530 Fax 07 31762201	Ph 07 3275 6278 Fax 07 3275 6228	N/A	N/A

# 16 GP Referral Criteria 2010

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Ophthalmology cont	<ul style="list-style-type: none"> <li>Relevant psychological and social issues impacting on activities of daily living:               <ul style="list-style-type: none"> <li>* Driving / work/leisure/ mobility</li> </ul> </li> <li>Any social support or if lives alone Note if patient is a contact lens user</li> <li>Visual acuity and best corrected visual acuity with glasses</li> <li>Optometry report if available Computerised perimetry results if available</li> <li>If diabetic, indication of recent control of BSL e.g HbA1c</li> </ul>	Ph 07 31762530 Fax 07 31762201	Ph 07 3275 6278 Fax 07 3275 6228	N/A	N/A
<b>Orthopaedics</b> <ul style="list-style-type: none"> <li>Hand &amp; Upper Limb</li> <li>Spine</li> <li>Hip &amp; Knee</li> <li>Foot &amp; Ankle</li> <li>Upper Limb Trauma</li> <li>Lower Limb Trauma</li> <li>Pelvis &amp; Acetabulum</li> <li>Orthopaedic Oncology</li> <li>Orthopaedic Fracture</li> </ul>	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>Xray, CT, EMG</li> <li>Bone/Joint pain (including shoulders)               <ul style="list-style-type: none"> <li>* Plain X-ray – 2 planes AP &amp; lateral</li> </ul> </li> <li>Soft tissue swelling               <ul style="list-style-type: none"> <li>* Ultrasound if diagnosis uncertain</li> </ul> </li> <li>Nerve entrapment               <ul style="list-style-type: none"> <li>* Nerve conduction studies (all NCS referrals to PAH Neurology Department)</li> </ul> </li> <li>Inflammatory disease               <ul style="list-style-type: none"> <li>* FBC, ESR, CRP, Rheumatoid Factor, ANA</li> </ul> </li> </ul>	Ph 07 31762177 Fax 07 31765862	Ph 07 32756278 Fax 07 32756228  <i>Hand &amp; Upper Limb Hip &amp; Knee, Foot &amp; Ankle, Orthopaedic Fracture. Spine service not provided - please direct spine referrals to PAH</i>	Ph 07 32998981 07 32998672 Fax 07 32998953  <i>Hand &amp; Upper Limb Hip &amp; Knee, Foot &amp; Ankle, Orthopaedic Fracture only</i>	Ph 07 34883420 07 34883421 Fax 07 34883588  <i>Hand &amp; Upper Limb (Carpal Tunnel) Hip &amp; Knee (arthroscopy &amp; ACL repair) &amp; Orthopaedic Fracture only</i>
Orthopaedic Physiotherapy Screening Clinics (OPSC)	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>History and Management to date</li> </ul>	Ph 07 31762177 Fax 07 31765862	N/A	Ph 07 32998670	N/A
Paediatrics All clinics	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>Condition specific investigations</li> <li>Current functional limitations</li> </ul>	N/A	N/A	Ph 07 32998724 Fax 07 32998201 <i>Paediatric Development up to 5 years old only for children with significant delays in 2 or more developmental domains NO Paediatric ENT services</i>	Ph 07 34884253 Fax 07 34884252 <i>Paediatric Development Unit up to 17 years old.</i>
Child Protection		Child Protection Liaison Officer Ph 07 31762610 Fax 07 31765759	Child Protection Liaison Officer Ph 07 32755353 Fax 07 32755494	Child Protection Liaison Officer Ph 07 32999102 Fax 07 32998035	Child Protection Liaison Officer Ph 07 34884256 Fax 07 34884251

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Palliative Care	<p>Please include Referral Criteria as listed on page 2, and, Please triage the urgency of referral for this patient according to the following categories:</p> <ul style="list-style-type: none"> <li>• Urgent - needs to be contacted within 24 hours</li> <li>• Priority - needs to be contacted within 3 days</li> <li>• Routine - needs to be contacted within 7 days</li> </ul>	Ph 07 31766199 Fax 07 31762670	N/A	Ph 07 32999050 Fax 07 32999559	Ph 07 34883149 07 34883156 Fax 07 34883588
Plastic Surgery	Please include Referral Criteria as listed on page 2.	Ph 07 31766083 Fax 07 31762502	N/A	N/A	N/A
Renal and Transplant Service	<p>Please include Referral Criteria as listed on page 2, and,</p> <ul style="list-style-type: none"> <li>• ELFT</li> <li>• FBC</li> <li>• MSU</li> <li>• Urine protein : creatinine ratio (albumin:creatinine ratio for diabetics)</li> <li>• Relevant scan reports</li> <li>• For transplant recipient – calcineurin inhibitor through level (eg. Tacrolimus or cyclosporin level)</li> </ul>	Ph 07 31762615 Fax 07 31765480	N/A	Ph 07 32998551 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Respiratory	<p>Please include Referral Criteria as listed on page 2, and,</p> <ul style="list-style-type: none"> <li>• The degree that the presenting problem is affecting activities of daily living eg breathlessness.</li> <li>• The information provided to the patient (if relevant) eg possible lung cancer diagnosis</li> <li>• Recent pathology <ul style="list-style-type: none"> <li>* FBC, E/LFT, ABGs if applicable</li> <li>* any recent results of specific tests eg Pertussis, Legionella, Mycoplasma</li> </ul> </li> <li>• Xray and scan reports . <ul style="list-style-type: none"> <li>* <b>Patients are required to bring any radiology images with them to the appointment.</b></li> </ul> </li> <li>• Smoking history</li> </ul>	Ph 07 31766174 Fax 07 31766176	Ph 07 3275 6278 Fax 07 3275 6228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588

# 18 GP Referral Criteria 2010

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Respiratory cont	<ul style="list-style-type: none"> <li>Spirometry, if available</li> </ul> <p><i>Note: Referrals of patients with sleep disorders should be made on the specific Sleep Disorders Centre Referral Form</i></p>	Ph 07 31766174 Fax 07 31766176	Ph 07 3275 6278 Fax 07 3275 6228	Ph 07 32998981 Fax 07 32998953	Ph 07 34883149 07 34883156 Fax 07 34883588
Rheumatology	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>ESR</li> <li>CRP</li> <li>FBE</li> <li>E LFT</li> </ul> <p>If clinically appropriate: * RF/CCP antibodies/ANA/DNA/ENA</p>	Ph 07 31765900 Fax 07 31767474	Ph 07 3275 6278 Fax 07 3275 6228	N/A	N/A
Sexual Health	<i>Please include Referral Criteria as listed on page 2.</i>	<b>Referral form to be faxed to Princess Alexandra Sexual Health (PASH) at 07 3176 5540 and a copy given to patient to arrange appointment on 07 3176 5881 Medicare Card is NOT required</b>			
Sleep Disorder	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <p>Note: Referrals of patients with sleep disorders should be made on the specific Sleep Disorders Centre Referral Form Patients must bring full copies of any previous sleep studies</p>	Ph 07 31765751 Fax 07 31767096	N/A	N/A	N/A
Spinal (cord) Injury (paraplegia /quadriplegia)	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Recent micro urine</li> </ul> <p><b>Patients with back pain and disc disease should be referred to the Orthopaedic Spinal Clinic</b></p>	Ph 07 31762641 Fax 07 31765644	N/A	N/A	N/A
Stomal Therapy	<p><i>Please include Referral Criteria as listed on page 2, and,</i></p> <ul style="list-style-type: none"> <li>Phone to arrange an appointment. Urgent cases are seen on the day of referral where possible</li> </ul>	Ph 07 31762675 Fax 07 31766458	Ph 07 3275 6245	CNC: Ph 07 3299 9107 Clinical Nurse: Ph 07 3299 9104 Fax 07 3299 8953	N/A

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Thoracic Surgery	<p>Please include Referral Criteria as listed on page 2, and,</p> <ul style="list-style-type: none"> <li>• Risk factors</li> <li>• Exercise tolerance</li> <li>• Occupational exposure</li> <li>• Previous Xrays / CT scans for comparison</li> <li>• Chest xray</li> <li>• U&amp;E's / LFT's</li> <li>• ECG</li> <li>• FBC</li> <li>• Respiratory Function tests</li> <li>• CT scan if lung lesion present</li> </ul>	Ph 07 317626377 Fax 07 31766378	N/A	N/A	N/A
Upper Gastrointestinal Surgery	<p><b>Please see General Surgery</b>  <b>For PAH only: For proven upper gastrointestinal cancer, referrals should be directed to Cancer Services referral management (phone 3176 6199 or fax 3176 2670).</b></p>				
Urology	<p>Please include Referral Criteria as listed on page 2, and,</p> <p>Macroscopic haematuria</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS, CYTOLOGY X 3</li> <li>* ELFTs, FBC, ESR</li> <li>* CT: NON-CON, CON, DELAYED EXCRETORY PHASE or IVP</li> </ul> <p>Microscopic haematuria</p> <ul style="list-style-type: none"> <li>* &lt; 50 NON-SMOKERS:</li> <li>* MSU FOR MCS, CYTOLOGY X 3</li> <li>* RENAL USS + KUB</li> <li>* ALL OTHERS:</li> <li>* MSU FOR MCS, CYTOLOGY X 3</li> <li>* ELFTs</li> <li>* CT: NON-CON, CON, DELAYED EXCRETORY PHASE</li> </ul> <p>Renal / staghorn / ureteric calculi</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* ELFTs, FBC, ESR</li> <li>* KUB + NON-CONTRAST CT</li> <li>* FOR URETERIC STONES - PLEASE REPEAT CT +KUB 2/52 AFTER FIRST PRESENTATION OR 1/52 PRIOR TO APPOINTMENT TO CONFIRM STONE STILL PRESENT</li> </ul>	Ph 07 31766408 07 31766409 Fax 07 31762542	Ph 07 3275 6278 Fax 07 3275 6228	N/A	Ph 07 34883420 Fax 07 34883588

# 20 GP Referral Criteria 2010

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Urology cont	<p>Elevated PSA / Prostate disease</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* PREVIOUS PSA RESULTS</li> <li>* ELFTS</li> <li>* FBC</li> <li>* ESR</li> <li>* MEDICAL / SURGICAL HISTORY</li> <li>* FAMILY HISTORY</li> </ul> <p>Bladder outlet obstruction / LUTS</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* PSA, ELFTS, FBC, ESR</li> <li>* IPSS</li> <li>* RENAL USS WITH RESIDUAL</li> <li>* PHARMACOLOGICAL HISTORY</li> </ul> <p>Urethral stricture</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* RENAL USS WITH RESIDUAL</li> <li>* PHARMACOLOGICAL HISTORY</li> <li>* SURGICAL / MEDICAL HISTORY</li> <li>* ASCENDING AND DESCENDING URETHROGRAM</li> </ul> <p>Incontinence</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* ELFTS</li> <li>* TIME AND VOLUME CHART</li> <li>* RESIDUAL VOLUMES (USS)</li> <li>* MEDICAL / SURGICAL / SOCIAL HISTORY</li> </ul> <p>Renal lesions / Cysts</p> <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* FBC</li> <li>* ELFTS</li> <li>* ESR</li> <li>* RENAL USS</li> <li>* CYTOLOGY X 3</li> <li>* TRIPLE PHASE CT (IF SOLID LESION OR SUGGESTED BY USS)</li> </ul>	<p>Ph 07 31766408 07 31766409 Fax 07 31762542</p>	<p>Ph 07 3275 6278 Fax 07 3275 6228</p>	N/A	<p>Ph 07 34883420 Fax 07 34883588</p>

Specialty	Referral Criteria	PAH	QEII	Logan	Redland
Urology cont	Urinary tract infection <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* PREVIOUS MSU RESULTS</li> <li>* RENAL TRACT USS WITH POST VOID RESIDUAL</li> <li>* PHARMACOLOGICAL HISTORY</li> </ul> Testicular tumour / mass <ul style="list-style-type: none"> <li>* MSU FOR MCS</li> <li>* ELFTS</li> <li>* FBC</li> <li>* ESR</li> <li>* <math>\diamond</math>-FETOPROTEIN (<math>\diamond</math>FP)</li> <li>* <math>\diamond</math>-hCG, LDH</li> <li>* USS TESTES, CXR</li> <li>* MEDICAL / FAMILY HISTORY</li> </ul> Penile Ca+ / Penile discharge / Erectile dysfunction <ul style="list-style-type: none"> <li>* MSU FOR MCS, CYTOLOGY X 3</li> <li>* URETHRAL SWAB</li> <li>* SEXUAL HEALTH HISTORY</li> <li>* MEDICAL / SURGICAL HISTORY</li> </ul>	Ph 07 31766408 07 31766409 Fax 07 31762542	Ph 07 3275 6278 Fax 07 3275 6228	N/A	Ph 07 34883420 Fax 07 34883588
Vascular Medicine	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>• Include Carotid Duplex Scan report</li> <li>• Wounds: Include current wound plan</li> </ul>	Ph 07 31765900 Fax 07 31767474	N/A	N/A	N/A
Vascular Surgery	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>• Please include any relevant investigations that have been performed ie: CT Scan</li> </ul>	Ph 07 31765900 Fax 07 31767474	Ph 07 3275 6278 Fax 07 3275 6228	N/A	Ph 07 34883420 Fax 07 34883588
Wound Clinic (Vascular Ulcers)	<i>Please include Referral Criteria as listed on page 2, and,</i> <ul style="list-style-type: none"> <li>• Please include current wound plan</li> </ul>	Ph 07 31765900 Fax 07 31767474	N/A	Ph 07 32998981 Fax 07 32998953	N/A

Online version of this information:  
[www.health.qld.gov.au/metrosouth](http://www.health.qld.gov.au/metrosouth)

**Queensland Health**  
Metro South Health Service District



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