General Endocrinology Clinic Referral Guidelines

Austin Health General Endocrinology Clinic holds weekly sessions to manage general Endocrine problems.

Department of Health clinical urgency categories for Specialist Clinics					
Urgent: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt. For emergency cases please send the patient to the Emergency department. These include patients with severe hyperthyroidism, sodium or potassium abnormalities, untreated pituitary hormone abnormalities, severe hypercalcaemia and suspicions of malignancy.					
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.					
Exclusions: **Diabetes, Lipids, Osteoporosis, Obesity (unless concurrent with another general endocrine problem.) These conditions are managed in other specialist Endocrine clinics.**					
Condition / Symptom	**GP Management**	**Investigations Required Prior to Referral**	**Expected Triage Outcome**	**Expected Specialist Intervention Outcome**	**Expected number of Specialist Appointments**
Hyperthyroidism	**When to Refer:** All patients with new diagnoses **Previous treatment already tried:** Carbimazole or propylthiouracil if appropriate	**To be included in referral** Thyroid function tests, TSH receptor antibodies +/- thyroid uptake scan **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** if severe and untreated i.e. T4 >40 **Routine:** If patient treated and stable	Assessment and investigation of cause. Initiation of treatment. Monitoring of treatment.	10 +
Hypothyroidism	**When to Refer:** Difficult to control with thyroxine **Previous treatment already tried:** Thyroxine	**To be included in referral** Thyroid function tests, thyroid antibodies **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** If untreated and T4 <8 **Routine:** This will be the majority	Assessment and identification of complicating factors to treatment. Adjustment of treatment.	3
Thyroid nodules	**When to Refer:** Suspicious thyroid	**To be included in referral** Serial ultrasound results. Thyroid	**Urgent:** N/A unless malignancy confirmed	Assessment for malignant potential which may	

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	nodules with any of the following features; single nodule, >1cm in size, increasing size on serial imaging, microcalcifications, increased vascularity, cervical lymphadenopathy, thyroid function abnormality, cold nodule on uptake scan **Previous treatment already tried:**	function tests. Any fine needle aspirate results or thyroid uptake scan. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Routine:** This will be the majority	include fine needle aspirate and ultrasound. Monitoring of size and for development of malignant features. To make decisions regarding surgical intervention.	
Pituitary adenoma	**When to Refer:** Any pituitary hormone abnormality or if pituitary adenoma >10mm in size **Previous treatment already tried:** N/A	**To be included in referral** Ideally: UEC, Prolactin, FSH, LH, early morning cortisol level, TSH, fT4, fT3 and if male, testosterone, if female, oestradiol. Visual field tests. MRI scans of pituitary if performed previously. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** If any obvious hormonal excess or deficiency. Any visual impairment. **Routine:** All others	To be seen in multidisciplinary pituitary clinic. Assessment of pituitary hormones and size of adenoma. Development of management plan in conjunction with neurosurgical unit.	5+
Hypercalcaemia	**When to Refer:** Repeated biochemistry shows elevated calcium levels **Previous treatment already tried:** N/A	**To be included in referral** Detailed history and medication list. Serum calcium levels, parathyroid hormone levels, albumin. 24 hour urine calcium excretion. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** If patient is symptomatic from hypercalcaemia or if corrected calcium >3.0 mmol/L **Routine:** All others	Assessment of cause of hypercalcaemia and management plan.	5
Sodium abnormalities –	**When to Refer:** Persistent sodium	**To be included in referral** Detailed history and medication	**Urgent:** Sodium <130 mmol/L	Investigate cause and develop appropriate	5

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Hyponatraemia or Hypernatraemia	abnormality on repeat testing or if cause unclear. **Previous treatment already tried:** treatment of underlying cause i.e. cessation of offending medication	list. Serial biochemistry results. Serum sodium, electrolytes, osmolality. Urine sodium and urine osmolality. Thyroid function, cortisol levels. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	or >150 mmol/L, particularly if acute change. **Routine:**	management plan depending on cause	
Addison's disease	**When to Refer:** All patients with suspected Addison's disease **Previous treatment already tried:**N/A	**To be included in referral** History and investigations including cortisol, UEC. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** untreated patients not on cortisol replacement **Routine:** treated patients on appropriate cortisol replacement	Confirmation of diagnosis and treatment with cortisol +/- mineralocorticoid replacement. Patient education.	Indefinite
Adrenal adenoma	**When to Refer:** All newly diagnosed adrenal adenomas if GP is not able to monitor size or assess functional status. **Previous treatment already tried:** N/A	**To be included in referral** Blood pressure readings, medication list. Imaging studies i.e. serial CT scans. Adrenal hormones if already performed i.e. 24 hour urinary free cortisol excretion, 1mg dexamethasone suppression test, 24 hour urinary catecholamines, plasma metanephrines, aldosterone to renin ratio. **Instruct patient to bring diagnostic results to the Specialist Clinic appointment.**	**Urgent:** Suspicion of malignancy i.e. metastases **Routine:** All others	Assessment of adenoma size and hormonal functional status. Monitoring of size (usually 6 monthly for at least 2 years).	5