Department of Health clinical urgency categories for specialist clinics
Urgent: A referral is urgent if the patient has a condition that has major functional impairment and/or moderate risk of permanent damage to an organ/bone/tissue/system if not seen within 30 days.
Semi Urgent: Referrals should be categorised as Semi Urgent where the patient has a condition that has the potential to deteriorate within 30-90 days.
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: Nil

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Condition / Symptom	Criteria for Referral	Information to be included	Expected Triage Outcome	Austin Specific Guidance Notes

Epilepsy and seizures
 	
Direct to Emergency Department for:
• **Seizure with:**
  ○ **focal deficit post-ictally**
  ○ **seizure associated with recent trauma**
  ○ **persistent severe headache > 1 hour post-ictally**
  ○ **seizure with fever.**
• **Prolonged or recurrent seizure (more than one in 24 hours) with incomplete recovery**
• **Persisting altered level of consciousness**
	1. Suspected seizure.
	2. New diagnosis of epilepsy (suspected or confirmed).
	3. Frequent seizures, particularly convulsive seizures.
	4. Planning for pregnancy or pregnancy with epilepsy.
	5. Advice on, or review of, epilepsy management plan including driving assessment for commercial drivers, changes to medicines, the management of epilepsy with concurrent conditions.
		Must be provided:
		1. Onset, characteristics and frequency of seizures.
		2. If the patient is pregnant.
		
		Provide if available:
		1. Electroencephalogram results.
		2. Neuroimaging results.
		3. Current and complete medication history and recent therapeutic medication levels.		

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Headache
 	
Direct to Emergency Department for:
• **Headache with:**
  ○ **sudden onset or thunderclap headache**
  ○ **severe headache with signs of systemic illness (fever, neck stiffness, vomiting, confusion, drowsiness, dehydration)**
  ○ **severe disabling headache**
  ○ **severe headache associated with recent head trauma**
• **Headache suggesting temporal artheritis (focal neurological symptoms, altered vision, elevated erythrocyte sedimentation rate and C-reactive protein in patients > 50 years of age).**
	1. Chronic headache with concerning clinical signs
	2. Concerning features on neuroimaging (excluding age appropriate deep white matter)
	3. Severe frequent migraine impacting on daily activities (e.g. work, study, school or carer role) despite prophylactic treatment
	4. Chronic or atypical headache unresponsive to medical management (e.g. cluster headache, trigeminal neuralgia, medication overuse headache).
	
	Referral not appropriate for:
	• Mild or tension headache
	• Untreated typical migraine
	• Isolated migraine in patients with an established diagnosis
	• Chronic migraine already being managed by a neurologist.
		Must be provided:
		1. Onset, characteristics and frequency of headache
		2. Current and complete medication history (including non-prescription medicines, herbs and supplements)
		3. Any medicines previously tried, duration of trial and effect
		4. Erythrocyte sedimentation rate and C-reactive protein for patient > 50 years, or if giant cell arteritis or vasculitis suspected
		5. Details of any previous neurology assessments or opinions
		
		Provide if available:
		1. Neuroimaging results.		

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Motor weakness or paraesthesia Direct to Emergency Department for: • **Rapidly progressive neurological symptoms leading to weakness or imbalance.** Additional Comments: • Referrals for confirmed carpel tunnel syndrome should be directed to a surgical service.	1. Focal neuropathy or plexopathy of unclear cause 2. Suspected peripheral neuropathy 3. Persistent, unexplained sensory symptoms 4. Suspected or confirmed multiple sclerosis 5. Suspected or confirmed motor neurone disease	Must be provided: 1. History of symptoms, including distribution and timing 2. Current and previous imaging results 3. Details of any previous neurology assessments or opinions Provide if available: 1. Examination findings 2. Any nerve conduction study results 3. Full blood examination 4. Liver function tests 5. Fasting blood glucose level 6. Erythrocyte sedimentation rate and C-reactive protein 7. Thyroid stimulating hormone levels 8. Vitamin B12 and folate test results 9. Anti-double-stranded DNA test 10. Protein electrophoresis of serum 11. Syphilis, Hepatitis B, Hepatitis C or HIV results.		

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Movement disorders and dystonia Direct to Emergency Department for: • **Acute onset of a movement disorder e.g. severe ataxia, dystonia, hemiballismus** • **Acute dystonic crisis** • **Acute akinetic crisis** • **Neuroleptic malignant syndrome** • **Device-related infection in people with deep brain stimulator implants.** Additional Comments: • The referral should note if the request is for a second or subsequent opinion.	1. New or progressive tremor, non-essential tremor 2. Suspected Parkinson's disease or movement disorder 3. Motor or non-motor complications of Parkinson's disease leading to substantial disability. Referral not appropriate for: • Movement disorders that have already been assessed and have a current management plan	Must be provided: 1. History and description of abnormal movements, severity of symptoms and degree of functional impairment. Provide if available 1. Liver function tests 2. Full blood examination 3. Thyroid stimulating hormone levels 4. Previous investigations (e.g. nerve conduction study, electroencephalogram, CT or MRI of the brain).		
Stroke or transient ischaemic attack Direct to Emergency Department for: • **Transient ischaemic attack(s) in last 48 hours** • **Multiple or recurrent transient ischaemic attack episodes in the last seven days** • **Amaurosis fugax in last 48 hours** • **Persistent neurological deficit.**	1. Internal carotid stenosis (> 50%) on imaging with symptoms (excluding dizziness alone), more than two weeks after onset of symptoms 2. Asymptomatic internal carotid stenosis > 70% on imaging 3. An old stroke identified on imaging that has not been previously addressed. Referral not appropriate for:	Must be provided: 1. Timing and severity of symptoms 2. Neuroimaging results 3. Vascular imaging results 4. Current and complete medication history (including non-prescription medicines, herbs and supplements). Provide if available 1. Full blood examination		

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Immediately contact the neurology registrar to arrange an urgent neurology assessment for: • **Transient ischaemic attack(s) that has occurred more than 48 hours ago and within the last two weeks.**	• An old stroke identified on imaging that has been previously addressed • Age appropriate, asymptomatic deep white matter disease or T2-hyperintense lesions • Chronic vascular risk factors without an acute transient ischaemic attack or stroke • Primary prevention of vascular risk.	2. Liver function tests 3. Fasting blood glucose level 4. Fasting lipid profile 5. Any echocardiogram or Holter monitor results 6. International normalised ration (INR) > 1.5 in patients taking an anticoagulant medicine.		
Vertigo (neurology) Direct to Emergency Department for: • **Sudden onset debilitating vertigo where the patient is unsteady on their feet or unable to walk without assistance** • **Sudden onset vertigo with other neurological signs or symptoms (e.g. dysphasia, hemiparesis, diplopia, facial weakness)** • **Barotrauma with sudden onset vertigo.**	1. Chronic or episodic vertigo (e.g. suspected vestibular migraine) 2. Vertigo with other neurological symptoms. Referral not appropriate for: • Patients with mild or brief orthostatic dizziness • Dizziness due to a medicine, hypoglycaemia or chronic fatigue syndrome.	Must be provided: 1. Onset, duration, characteristics and frequency of vertigo and associated symptoms. Provide if available 1. Results of diagnostic audiology assessment 2. Neuroimaging results 3. Details of any previous neurology assessments or opinions 4. Results of diagnostic vestibular physiotherapy assessment or Epley manoeuvre Description of any of the following: 1. Functional impact of vertigo 2. Any associated		

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		otological or neurological symptoms 3. Any previous diagnosis of vertigo (attach correspondence) 4. Any treatments (medication or other) previously tried, duration of trial and effect 5. Any previous investigations or imaging results 6. Hearing or balance symptoms 7. Past history of middle ear disease or surgery. History of any of the following: 1. Cardiovascular problems 2. Neck problems 3. Neurological 4. Auto immune conditions 5. Eye problems 6. Previous head injury.		