RESPIRATORY Allergy & Asthma Referral Guidelines

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 (e.g. acute anaphylaxis or acute asthma) please send the patient to the Emergency department.
These include: Recent anaphylaxis or angioedema, History of life threatening asthma or hospital admission for asthma in past 12 months, Unstable asthma where spirometry is <70% predicted

Semi Urgent: Referrals should be categorised as Semi Urgent if the patient 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. Examples: Chronic severe urticaria, severe allergic rhinitis
Chronic rhino sinusitis, , assessment for immunotherapy for aeroallergens, non- anaphylactic food allergy, a

Exclusions: Eczema, non-allergic rhinitis, urticarial vasculitis/non-urticarial rash, contact dermatitis/patch testing, functional gut/malabsorption –lactose/fructose malabsorption, irritable bowel syndrome. Predominantly gastrointestinal symptoms without urticaria/angioedema triggered by food, e.g. abdominal pain, cramping or bloating, coeliac disease. Immunodeficiency - please refer to immunology, vasculitis, drug/vaccine allergy -please refer to ID Drug and vaccine allergy clinic

Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention Outcome	Expected number of Specialist Appointments
Anaphylaxis/allergy	Identify a trigger if possible. Provide patient with two Epipens® (Ongoing PBS supply must be approved by a specialist, the GP can contact the Allergist at the Austin to approve supply or it can be prescribed by a treating emergency physician). Provide patient with Epipen® action plan, available at: https://allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis	Perform single RAST blood tests, to identify sensitization to a suspected trigger if available.	**Urgent:** 30 days	Trigger identification Exclusion of mast cell disorder Anaphylaxis action plan provision and patient education	1-2+

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Asthma Life threatening attacks Moderate or severe persistent asthma not responding to standard dose preventer therapy Atypical signs or symptoms or difficulties confirming the diagnosis of asthma The patient is requiring frequent prednisolone for the management of their asthma. Complicating comorbidities Further diagnostic tests are required, such as bronchial provocation or complex lung function testing Patient has difficulty with self-management Additional guidance needed regarding trigger avoidance or treatment complications	You have addressed the issues highlighted in the Australian asthma handbook troubleshooting checklist: http://www.asthmahandbook.org.au/table/show/58 Please ensure the patient brings the results of any investigations (lung function test results, blood results, and any chest radiology) as well as their current inhalers to their appointment.	Refer the patient for spirometry with pre and post bronchodilator measurements Identification of triggers and clarification of atopy: FBE, IgE, RAST house dust mite and rye grass	**Semi Urgent**: 30-60 days	Phenotyping of asthma Assessment for suitability for biological therapy Assessment of complicating comorbidities Asthma action plan and education Optimisation of asthma management	10+
Chronic rhinosinusitis Severe disease is present impact of symptoms on quality of life and function CT sinus has confirmed sinusitis Comorbid nasal polyposis or asthma is present	Patient has failed to respond to standard therapy Trial of intranasal corticosteroids and/or sinus rinses	CT sinus ENT referral concurrent	Routine	Assessment for nasal polyposis Assessment for allergic trigger	2-3

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Chronic severe urticaria (Hives)	**Refer if:** Failure to respond to two regular different antihistamine combinations, each tried for a period of six to eight weeks (with standard dose up to four times daily). AND Failure to respond to H1 blocker (ranitidine 300mg daily) trialled for a period of six to eight weeks (Can be given concurrently) Associated distressing or life threatening angioedema		Routine	Assessment for suitability of immune-suppression or Omalizumab	2-3
Angioedema (Soft tissue swelling) Patient has experienced life-threatening tongue or laryngeal angioedema Recurrent oedema presenting at a young age (<40 years) or family history of angioedema	Withdraw potentially implicated medication (Aspirin, NSAIDs and ACE inhibitors/ARBs) Trial of antihistamine therapy (up to four times daily)	FBE, UEC, LFTs, CRP or ESR, C4 (complement protein)	Routine unless life threatening	Exclude hereditary angioedema Assessment for triggers Assessment whether likely histaminergic or bradykinin mediated and treat as appropriate	2+

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Severe Aero allergy /Allergic rhinitis (Hay fever) Severe disease is present – impact of symptoms on quality of life and function. Associated asthma or thunderstorm asthma. Evidence of allergy is present correlating with patient symptoms (see investigations)	Trials of intranasal corticosteroids or intranasal corticosteroid/antihistamine combination with correct technique. For more information please see: https://www.allergy.org.au/images/pcc/ASCIA_Allergic_Rhinitis_Treatment_Plan_2020.pdfTreatment trial of non-sedating oral antihistamines	Perennial symptoms and positive RAST for House dust mite Seasonal symptoms and positive RAST for grass pollens	Routine	Skin prick testing Asthma assessment Allergic rhinitis management plan Immunotherapy if appropriate	2-3+