

Please fax your referral to The Alfred Gastroenterology Department on 9076 2194. [The Alfred Outpatient Referral Form](#) is available to print and fax. Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

You will be notified when your referral is received. Your referral may be declined if it does not contain essential information required for triage, or if the condition is not appropriate for referral to a public hospital, or is a condition not routinely seen at Alfred Health.

Referral to Victorian public hospitals is not appropriate for:

- Fatty liver with normal liver function tests
- Patients with no sentinel findings, who have not had an adequate trial of treatment (e.g. regular osmotic laxatives)
- Laxative dependence
- Positive coeliac gene test without positive coeliac serology
- Patients with more than 12 months of constipation symptoms, with no sentinel findings, who have not had an adequate trial of treatment
- Diarrhoea < 4 weeks duration without sentinel findings
- Patients who are hepatitis B surface antigen (HbsAg) negative, unless they are pregnant, immunosuppressed, or starting immunosuppressant medicines and are hepatitis B core antibody (HbcAb) positive
- Patients who are hepatitis C (HCV) RNA negative who are not at ongoing risk of cirrhosis.

The following conditions are not routinely seen at Alfred Health:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age.

Please refer to the Department of [Statewide Referral Criteria for Specialist Clinics](#) for further information when referring to Gastroenterology specialist clinics in public hospitals.

Some clinics offer an MBS-billed service. There is no out of pocket expense to the patient. MBS-billed services require a current referral to a named specialist – please provide your patient with a 12 month referral addressed to the specialist of your choice. Please note that your patient may be seen by another specialist in that clinic in order to expedite his or her treatment.

The times to assessment may vary depending on size and staffing of the hospital department.

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, or if you require an urgent specialist opinion, please contact the Gastroenterology Registrar on call on 9076 2000.

Please include in your referral:

<p>Demographic details:</p> <ul style="list-style-type: none"> • Date of birth • Patient's contact details including mobile phone number • Referring GP details • If an interpreter is required • Medicare number. 	<p>Clinical information:</p> <ul style="list-style-type: none"> • Reason for referral • Duration of symptoms • Relevant pathology and imaging reports • Past medical history • Current medications.
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Dysphagia (gastroenterology)

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Progressively worsening oropharyngeal or throat dysphagia
- Inability to swallow with drooling or pooling saliva
- Unresolved food bolus obstruction.

Criteria for referral to public hospital specialist clinic services:

- Recent onset dysphagia with any of the following:
 - symptoms for less than 12 months
 - progressive symptoms
 - anaemia
 - haematemesis
 - weight loss ($\geq 5\%$ of body weight in previous 6 months)
 - painful swallowing
 - symptoms of aspiration
 - previously resolved bolus obstruction.

Information to be included in the referral:

Information that **must** be provided:

- History of dysphagia and other symptoms over time
- Any previous gastroscopy or other relevant investigations.

Provide if available:

- Barium swallow, relevant imaging or gastroscopy results.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Referrals for oropharyngeal dysphagia should be directed to an ENT service provided by the health service.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Dysphagia that has persisted for more than 12 months with none of the following:
 - progressive symptoms
 - anaemia
 - weight loss
 - painful swallowing
 - aspiration
 - previous resolved bolus obstruction.

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Gastroesophageal reflux

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Potentially life-threatening symptoms suggestive of acute severe upper gastrointestinal tract bleeding.

Criteria for referral to public hospital specialist clinic services:

- Recent onset, persistent symptoms of gastroesophageal reflux with:
 - unintended weight loss ($\geq 5\%$ of body weight in previous 6 months)
 - dysphagia
 - vomiting
 - iron deficiency that persists despite correction of potential causative factors.
- Surveillance for previously diagnosed Barrett's oesophagus.

Information to be included in the referral:

Information that **must** be provided:

- Onset, characteristics and duration of sentinel findings e.g. changes in weight, ferritin levels
- Previous endoscopy results
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Patients with any other gastroesophageal reflux
- Patients with controlled symptoms
- Patients that cease treatment and symptoms return
- Belching
- Halitosis
- Screening for Barrett's oesophagus in patients with gastroesophageal reflux without additional symptoms.

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Weight loss

Evaluation

Key points:

- Consider both GI and non-GI causes
- Definitely document reported weight loss
- Dietary history including any change in amount or type of diet
- Age and gender
- Associated symptoms
- Smoking and alcohol
- FBE + ESR
- CXR + CT abdomen/pelvis (where appropriate)
- TFTs
- Creatinine
- Electrolytes
- LFTs
- Fasting glucose
- Urinalysis.

Management:

- Lifestyle changes.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Vomiting and nausea

Evaluation

Key points:

- Consider both GI and non-GI causes
- Age and gender
- Associated symptoms
- Smoking and alcohol
- Drugs
- FBE + ESR
- Creatinine
- U + Es
- LFTs
- Fasting glucose
- Urinalysis
- Urine HCG.

Management:

- Symptomatic management with standard anti-emetics, etc.
- Stop potential emetogenic drug/s if appropriate
- Lifestyle modifications if indicated.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Upper gastrointestinal haemorrhage (haematemesis and/or melaena and/or haematochezia) – Acute

Direct to the Emergency Department for:

- Haemodynamically unstable
- Older patients (> 60) and those with significant co-morbid disease are at very high risk.

Management:

- Resuscitation and ambulance transfer.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Upper gastrointestinal haemorrhage (haematemesis and/or melaena and/or haematochezia) – Non-acute

Direct to the Emergency Department for:

- Definite melaena
- IF Hb < 100g/1 and symptomatic
- If on anticoagulants.

Immediately contact the gastroenterology registrar or 9076 2000 to arrange urgent gastroenterology assessment:

- If Hb > 100g/1 and asymptomatic.

Evaluation

Key points:

- Check FBE
- Older patients (> 60) and those with significant co-morbid disease are at very high risk
- NOTE: Blood pressure, particularly in response to postural changes, is a good indicator of haemodynamic stability in these situations.

Management:

- Cease ulcerogenic drugs.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Persistent iron deficiency

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Shortness of breath or chest pain, syncope or pre-syncope with iron deficiency (ferritin below the lower limit of normal).

Criteria for referral to public hospital specialist clinic services:

- Persistent iron deficiency in men and post-menopausal women with either:
 - ferritin < 30 µg/L
 - ferritin 30-100 µg/L in the presence of inflammation (e.g. C-reactive protein (CRP) ≥ 5 mg/L)
- Iron deficiency that persists despite correction of potential causative factors
- Iron deficiency in pre-menopausal women:
 - with positive coeliac serology
 - with positive faecal occult blood test
 - that persists despite treatment of menorrhagia, with good cycle control.

Information to be included in the referral

Information that **must** be provided:

- History of menorrhagia
- Dietary history, including red meat intake
- Iron studies or serum ferritin
- Full blood examination
- Coeliac serology results
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Faecal occult blood test
- Faecal calprotectin
- Any family history of gastrointestinal cancer.

Persistent iron deficiency, continued.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Referrals for iron deficiency related to persistent, heavy menstrual bleeding should be made to suitable community-based services wherever possible (see 1800 My Options). Where this is not practicable, referrals should be directed to a gynaecology service provided by the health service.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Iron deficiency in pre-menopausal women with:
 - no positive coeliac serology
 - negative faecal occult blood test
 - managed menorrhagia and with good cycle control
 - Isolated low serum iron
 - Non-iron deficiency anaemia without evidence of blood loss
 - Vegetarian diet without iron supplementation.

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Low abdominal pain

Direct to the Emergency Department for:

- Acute onset severe pain
- Patient is significantly dehydrated
- Septic or likely gastrointestinal haemorrhage.

Evaluation

Key points:

Alarm symptoms:

- Age > 50
- Weight loss
- PR bleeding
- New onset
- Anaemia or iron deficiency
- Change in diameter of stools
- Abdominal mass
- Rectal prolapse
- Past history of polyps/cancer
- Family history of bowel cancer.

Assessment:

- Acute vs. chronic
- Associated symptoms
 - Change in bowel habit
 - PR bleeding
 - Abdominal distention
 - Bloating
 - Vomiting
- Age and gender
- Risk factors:
 - Recent overseas travel
 - History of diverticular disease
 - Previous abdominal surgery.

Low abdominal pain, continued.

Investigations:

- FBE
- U + Es
- LFTs
- Inflammatory markers
- Iron studies
- Pregnancy test in women of childbearing age
- MSU
- Faecal microscopy and culture
- Rectal exam
- Bimanual exam in females with pelvic pain
- AXR
- If female, consider pelvic ultrasound
- Depending on location/quality of pain consider abdominal ultrasound, CT scan to exclude diverticulitis or CTU to exclude nephrolithiasis.

Management:

- Treat as appropriate depending on clinical assessment and investigation results
- If no response to initial therapy refer to general gastroenterology clinic for ongoing investigation and management
- If chronic history, no alarm features, negative investigations and patient meets ROME III for irritable bowel syndrome consider referring directly to the Functional Gastrointestinal Disorders clinic
- ROME III:
 - At least 12 weeks, which need not be consecutive, in the preceding 12 months of abdominal discomfort or pain that has two of three features:
 - Relieved with defecation; and/or
 - Onset associated with a change in frequency of stool; and/or
 - Onset associated with a change in form (appearance) of stool.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral. Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Diarrhoea with sentinel findings

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Severe diarrhoea with dehydration or when the person is systemically unwell.

Criteria for referral to public hospital specialist clinic services:

- Diarrhoea > 4 weeks duration, affecting activities of daily living, with one or more of the following:
 - bloody diarrhoea
 - nocturnal diarrhoea
 - weight loss (\geq 5% of body weight in previous 6 months)
 - abdominal or rectal mass
 - inflammatory markers in the blood or stool
 - iron deficiency that persists despite correction of potential causative factors.

Information to be included in the referral

Information that **must** be provided:

- Frequency and duration of diarrhoea
- Onset, characteristics and duration of sentinel findings (e.g. erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), faecal microscopy and culture and Clostridium difficile toxin)
- Previous colonoscopy results
- Coeliac serology
- Full blood examination
- Liver function tests.

Provide if available:

- Previous histology results
- Details of any previous gastroenterology assessments or opinions
- Iron studies
- Thyroid stimulating hormone levels
- Faecal calprotectin
- Faecal occult blood test
- Recent travel history.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

See also: [inflammatory bowel disease](#).

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Diarrhoea < 4 weeks duration without sentinel findings.

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Chronic refractory diarrhoea

DHHS [Statewide referral criteria](#) apply for this condition.

Criteria for referral to public hospital specialist clinic services:

- Chronic refractory diarrhoea lasting more than 4 weeks with refractory symptoms (following an adequate trial of treatment) that affect the person's activities of daily living.

Information to be included in the referral

Information that **must** be provided:

- Onset, characteristics and duration of symptoms
- Details of previous medical management including the course of treatment and outcome of treatment
- Details of any previous gastroenterology assessments or opinions
- Previous histopathology results.

Provide if available:

- Full blood examination
- Iron studies
- Vitamin B12 and folate test results
- 25-OH vitamin D results
- Faecal calprotectin
- Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)
- Previous colonoscopy results.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

The referral should note that the request is for advice on, or review of, the current management plan as requests for a second opinion will usually not be accepted.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Laxative dependence.

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Altered bowel habits including worsening constipation

Immediately contact the gastroenterology registrar on 9076 2000 to arrange urgent gastroenterology assessment:

- For patients > 40 years
- If results abnormal and/or clinical suspicion of organic large bowel disease.

Evaluation

Key points:

If:

- Age > 40 and/or
- Alarm symptoms and/or
- Family history of colorectal cancer or
- Inflammatory bowel disease, please provide:
 - Recent antibiotic usage
 - FBE, CRP, Iron studies
 - Stools M, C and S, ova and parasites, *C. difficile* toxin (CDT)
 - FOBs
 - Rectal examination.

If:

- Age < 40 and/or
- No alarm symptoms
- Normal lab tests
- No family history of colorectal cancer, inflammatory bowel disease or polyps, please provide:
 - Recent antibiotic usage
 - FBE, CRP, Iron studies
 - Stools M, C and S, ova and parasites, *C. difficile* toxin (CDT)
 - FOBs
 - Rectal examination.

Management:

- For <40 year old patients without sentinel findings, manage symptomatically if results suggest functional large bowel disorder (irritable bowel) e.g. bulking agents, antispasmodics, antidiarrhoeals, lifestyle advice, etc. (slow introduction of fibre – 3 months).

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Constipation with sentinel findings

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to Emergency Department for:

- Suspected large bowel obstruction
- Faecal impaction that has not responded to adequate medical management.

Criteria for referral to public hospital specialist clinic services:

- Constipation in patients with a duration of more than 6 weeks but less than 12 months, with any of the following:
 - > 40 years of age
 - rectal bleeding
 - positive faecal occult blood test
 - weight loss ($\geq 5\%$ of body weight in previous 6 months)
 - abdominal or rectal mass
 - iron deficiency that persists despite correction of causative factors
 - patient or family history of bowel cancer (first degree relative < 55 years).

Information to be included in the referral

Information that **must** be provided:

- Onset, characteristics and duration of constipation and sentinel findings
- Current and previous colonoscopy results
- Full blood examination
- Iron studies.

Provide if available:

- Current and previous histology results
- Details of any previous gastroenterology assessments or opinions
- Faecal occult blood test
- Thyroid stimulating hormone levels.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

As part of the referral assessment, patients may be triaged to colonoscopy prior to the appointment at a specialist clinic.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Patients with more than 12 months of symptoms, with no sentinel findings, who have not had an adequate trial of treatment.

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Chronic refractory constipation

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Suspected large bowel obstruction
- Faecal impaction that has not responded to adequate medical management.

Criteria for referral to public hospital specialist clinic services:

- Constipation lasting more than 12 months with refractory symptoms that affect the person's activities of daily living despite an adequate trial of treatment.

Information to be included in the referral

Information that **must** be provided:

- Onset, characteristics and duration of symptoms
- Details of previous medical management including the course of treatment and outcome of treatment
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Thyroid stimulating hormone levels
- Serum calcium.

Provide if available:

- Current and previous colonoscopy results
- Details of any previous gastroenterology assessments or opinions.
- Current and previous imaging results.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

The referral should note that the request is for advice on, or review of, the current management plan as requests for a second opinion will usually not be accepted.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Patients with no sentinel findings, who have not had an adequate trial of treatment (e.g. regular osmotic laxatives)
- Laxative dependence.

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Coeliac disease

DHHS [Statewide referral criteria](#) apply for this condition.

Criteria for referral to public hospital specialist clinic services:

- Positive coeliac serology
- Advice on, or review of, symptomatic coeliac disease (previous histological diagnosis) not responding to dietary and medical management.

Information to be included in the referral

Information that **must** be provided:

- Coeliac serology results or previous histology results
- Full blood examination
- Iron studies.

Provide if available:

- Gastrointestinal symptoms (e.g. diarrhoea, weight loss)
- Previous gastroscopy results
- Previous histology results
- Previous gastroenterology assessments or opinions
- Urea and electrolytes
- Liver function tests
- Details of previous medical management including the course of treatment and outcome of treatment
- Details of any other autoimmune conditions.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Positive coeliac gene test without positive coeliac serology.

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Inflammatory bowel disease

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Acute severe colitis: patient with > 6 bloody bowel motions per 24 hours plus at least one of:
 - Temperature > 37.8°C
 - Pulse rate > 90 bpm
 - Haemoglobin < 105 gm/L
 - Raised inflammatory markers (erythrocyte sedimentation rate (EST) > 30 mm/hr or C-reactive protein (CRP) > 30 mg/L)
- Suspected or known Crohn's disease with acute complications:
 - Bowel obstruction
 - Sepsis or intra-abdominal or pelvic abscess.

Criteria for referral to public hospital specialist clinic services:

- Known inflammatory bowel disease.
- Strongly suspected inflammatory disease based on:
 - recurrent perianal fistulas or abscesses
 - imaging results that strongly suggest Crohn's disease or colitis
 - endoscopy findings consistent with inflammatory bowel disease.

Information to be included in the referral

Information that **must** be provided:

- Current and previous colonoscopy results*
- Current and previous imaging results.
- Inflammatory marker result (erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)).
- Full blood examination.
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Faecal calprotectin.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

See also: [Diarrhoea](#) or abnormal imaging or colonoscopy results.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

*Please include histopathology with current and previous colonoscopy results.

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Rectal bleeding

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Potentially life-threatening symptoms suggestive of acute severe lower gastrointestinal tract bleeding

Criteria for referral to public hospital specialist clinic services:

- Rectal bleeding in patients with any of the following:
 - 40 years or older
 - unintended weight loss ($\geq 5\%$ of body weight in previous 6 months)
 - abdominal or rectal mass
 - recent change in bowel habits
 - iron deficiency that persists despite correction of potential causative factors
 - patient or family history of bowel cancer (first degree relative < 55 years).

Information to be included in the referral

Information that **must** be provided:

- Onset, characteristics and duration of symptoms
- Full blood examination
- Urea and electrolytes
- Iron studies
- Previous and current gastrointestinal investigations and results
- Patient age
- Details of relevant family history of gastrointestinal or colorectal cancers.

Provide if available:

- Current and previous colonoscopy results.

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Rectal bleeding, continued.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Referrals for colonoscopy requested for a positive faecal occult blood test should be made using Victoria's colonoscopy referral information form.

Referrals for severe haemorrhoids should be directed to colorectal service provided by the health service.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Persistent but unchanged symptoms previously investigated
- If the patient has had a full colonoscopy in the last 2 years for the same symptoms
- Untreated anal fissures
- Bleeding is known to be coming from haemorrhoids.

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Jaundice

Direct to the Emergency Department for:

- Suspected acute, severe or fulminant hepatic failure
- Severe hepatitis with jaundice (depending on severity).

Immediately contact the gastroenterology registrar on 9076 2000 to arrange urgent gastroenterology assessment:

- Severe hepatitis with jaundice (depending on severity)
- Obstructive jaundice (dilated ducts on imaging)
- Unexplained non-obstructive cholestatic jaundice.

Evaluation

Key points:

- Acute vs chronic
- Complete drug and alcohol history (including paracetamol, recreational drugs, natural therapies)
- Overseas travel
- Risk factors for hepatitis virus (IDU, tattoos, sexual history, hepatitis contacts, needle stick)
- Family history liver disease
- Symptoms: pruritus, dark urine, pale stools, abdominal pain
- Liver functions tests:
 - Hepatitic (high AST, ALT), HAV, HBV, HCV, EBV, CMV tests and consider IgG and ANA and SMA
 - Cholestatic (high ALP and GGT) ultrasound to exclude obstruction
- FBE, INR, U&E (renal function).

Management:

- Avoid alcohol
- Rest
- Stop hepatotoxic drugs
- Regular clinical and laboratory review
- Balanced healthy diet.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Ascites

Direct to the Emergency Department for:

- Symptomatic marked as cites or new onset of ascites.

Immediately contact the gastroenterology registrar on 9076 2000 to arrange urgent gastroenterology assessment:

- Mild-moderate ascites.

Evaluation

Key points:

- Acute onset or chronic
- History of cirrhosis, chronic liver diseases, ascites, hepatitis, jaundice
- Risk factors for liver disease as above including alcohol use, overseas travel, viral hepatitis
- Drug history: oral contraceptive pill (women)
- Symptoms: fever, abdominal pain, weight gain, jaundice
- Liver functions tests (as above)
- Liver ultrasound with Doppler
 - Features of cirrhosis, portal hypertension (dilated portal vein, varices, splenomegaly)
 - Hepatic vein thrombosis (Budd Chiari)
 - Portal vein thrombosis
- FBE, INR, U&E (renal function).

Management:

- Avoid alcohol
- Rest
- Stop hepatotoxic drugs
- Dietary salt restriction
- Fluid restriction <1.5 l/d.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Abnormal liver function tests

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Acute liver failure
- Severe hepatic encephalopathy
- Aspartate transaminase (AST) > 2,000 U/L.

Criteria for referral to public hospital specialist clinic services:

- Abnormal liver function tests with:
 - platelet count < 120×10^9 per litre
 - splenomegaly
 - ascites
 - hepatic encephalopathy
 - genetic haemochromatosis (C282Y homozygotes and C282Y/H63D compound heterozygotes only).
- Abnormal liver function test with aspartate transaminase (AST) or alanine aminotransferase (ALT) ≥ 5 times the upper level of the normal range
- Two abnormal liver function test results performed at least 3 months apart with aspartate transaminase (AST) or alanine aminotransferase (ALT) 2-5 times the upper level of the normal range.

Information to be included in the referral

Information that **must** be provided:

- History of alcohol intake
- History of injectable drug use
- Current and historical liver function tests
- Full blood examination
- International normalised ration (INR) result
- Urea and electrolytes
- Upper abdominal ultrasound results
- Hepatitis B virus and Hepatitis C virus serology results
- History of diabetes
- Iron studies
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Abnormal liver function tests, continued.

Provide if available:

- Height, weight and body mass index
- Any relevant family history.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Fatty liver with normal liver function tests.

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Cirrhosis

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Acute liver failure
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy
- Severe ascites restricting movement and breathing.

Criteria for referral to public hospital specialist clinic services:

- Suspected cirrhosis suggested by one or more of the following:
 - evidence of cirrhosis on imaging
 - platelet count < 120 x 10⁹ per litre
 - ascites
 - hepatic encephalopathy
 - AST to platelet ratio index (APRI) > 2.0.

Information to be included in the referral

Information that **must** be provided:

- History of alcohol intake
- History of injectable drug use
- Current and historical liver function tests
- Full blood examination
- International normalised ration (INR) result
- Urea and electrolytes
- Upper abdominal ultrasound results
- Hepatitis B virus and Hepatitis C virus serology results
- History of diabetes
- Iron studies
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Height, weight and body mass index.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Hepatitis B

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Acute liver failure
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy
- Severe ascites restricting movement and breathing.

Criteria for referral to public hospital specialist clinic services:

- Patients who are hepatitis B surface antigen (HBsAg) positive
- Pregnant women who are hepatitis B core antibody (anti-HBc) positive
- Patients who are immunosuppressed or starting immunosuppressant medicines who are hepatitis B core antibody (anti-HBc) positive (e.g. transplant patients, starting chemotherapy).

Information to be included in the referral

Information that **must** be provided:

- Hepatitis B virus (HBV) serology results
- Hepatitis C virus and HIV serology
- Liver function tests
- Full blood examination
- Upper abdominal ultrasound results
- If pregnant, gestational age
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Previous liver biopsy results
- Details of previous medical management including the course of treatment and outcome of treatment.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Patients who are hepatitis B surface antigen (HBsAg) negative, unless they are pregnant, immunosuppressed, or starting immunosuppressant medicines and are hepatitis B core antibody (anti-HBc) positive.

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Hepatitis C

DHHS [Statewide referral criteria](#) apply for this condition.

Direct to the Emergency Department for:

- Acute liver failure
- Sepsis in a patient with cirrhosis
- Severe hepatic encephalopathy
- Severe ascites restricting movement and breathing.

Criteria for referral to public hospital specialist clinic services:

- Patients who are hepatitis C (HCV) RNA positive unable to be managed and treated in community-based services.

Information to be included in the referral

Information that **must** be provided:

- Hepatitis C virus serology, genotype and RNA results
- Hepatitis B virus serology results
- HIV serology results
- Liver function tests including aspartate transaminase (AST)
- Full blood examination
- Upper abdominal ultrasound results
- If pregnant, gestational age
- Current and complete medication history (including non-prescription medicines, herbs and supplements).

Provide if available:

- Previous liver biopsy results
- Details of previous medical management including the course of treatment and outcome of treatment
- History of alcohol intake
- History of injectable drug use, including if the patient is still injecting.

Additional comments:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

Referral to a public hospital is not appropriate for:

- Hepatitis C should managed and treated through suitable community-based services wherever possible
- Patients who are hepatitis C (HCV) RNA negative who are not at ongoing risk of cirrhosis.

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Pancreatic and biliary disorders

Direct to the Emergency Department for:

- Cholangitis
- Moderate/severe pancreatitis
- Complicated CBD stones
- Cholecystitis.

Evaluation

Key points:

- Pain (biliary – RUQ/epigastric; pancreatic – central radiating to back)
- Jaundice: painless with bilirubin above 200 suggests malignancy; epigastric/RUQ tenderness and/or fever with bilirubin below 200 suggests stone disease
- Charcot's triad (jaundice, pain, fever = cholangitis)
- Steatorrhea or malabsorption suggests exocrine pancreatic insufficiency
- Risk factors for pancreatitis:
 - Alcohol consumption
 - Known gallstones or previous cholecystectomy?
 - Preceding trauma?
 - Drugs causing pancreatitis?
 - Hypertriglyceridaemia/hypercalcaemia?

Investigations:

- Bloods
 - LFTs, FBEs, U + Es, clotting
 - Lipase, lipids, calcium, CRP
- Abdominal ultrasound should be the initial investigation for jaundice of RUQ pain
- Subsequent imaging may include:
 - CT scan, MRCP, endoscopic ultrasound
 - ERCP almost never used as a diagnostic procedure.

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Pancreatic and biliary disorders, continued.

Evaluation

Management:

- Uncomplicated gallstones:
 - Observe
- Acutely complicated gallstones (cholangitis, biliary colic, cholecystitis):
 - Refer to the Emergency Department
- Chronic pancreatitis:
 - Low fat diet
 - Pancreatic enzyme supplements
 - Non-narcotic analgesia
 - Alcohol abstention
 - Check for secondary diabetes
- Discussion with Gastroenterology registrar regarding early review or admission:
 - Jaundice thought to be obstructive
 - CBD stones
 - Biliary/pancreatic neoplasm
- Elective referral to Gastroenterology or General Surgery:
 - Uncomplicated gallstones
 - Chronic pancreatitis
 - Abnormal LFTs
 - Biliary/pancreatic imaging abnormalities.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Suspected irritable bowel syndrome/functional diarrhoea

Evaluation

Key points:

Please include:

- FBE
- Iron studies
- Liver function tests
- CRP
- Coeliac serology.

Please also include if previously performed:

- Results of prior endoscopy
- Faecal calprotectin
- Thyroid function tests
- Stool microscopy and culture.

Management:

- Refer to the Functional Gut Clinic.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Suspected functional dyspepsia

Evaluation

Key points:

Please include:

- FBE
- Iron studies
- Liver function tests
- Liver function tests
- H. Pylori status.

Please include if previously performed:

- Results of prior upper GI endoscopy
- Abdominal USS.

Management:

- Refer to the Functional Gut Clinic.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Chronic constipation

Evaluation

Key points:

Please include:

- FBE
- Iron studies.

Please include if previously performed:

- Results of prior endoscopy
- Calcium
- Thyroid function tests.

Management:

- Refer to the Functional Gut Clinic.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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Functional chronic abdominal pain

Evaluation

Key points:

Please include:

- FBE
- Iron studies
- Liver function tests
- CRP.

Please include if previously performed:

- Results of any prior GI endoscopy
- Any imaging studies e.g. Abdominal USS, CT, MRI.

Management:

- Refer to the Functional Gut Clinic.

Additional information:

Please include the essential [demographic details and clinical information](#) in the referral.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service.

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