REFERRAL GUIDELINES
Monash Children's General Paediatrics

Referral Form: The GP Referral Template is the preferred referral tool (previously known as the Victorian Statewide Referral Form) – GP Referral Template

This tool is housed in most major clinical software or can be downloaded from http://www.nhv.org.au/general-practice/2015/3/11/gp-referral-template

Click on category to advance to that page:

Neonatal follow up
- Preterm Babies
- Term Babies

Developmental Concerns
- Developmental delay
- Challenging behaviour
- Continence difficulties
- Learning difficulties

Growth Concerns
- Failure to thrive
- Feeding difficulties
- Obesity

Other General Paediatric Issues
- Asthma/Atopy
- Sleep
- UTI
- First Seizure

Services not provided
- Skin prick testing
- Multi-disciplinary Autism or Educational assessments
- Sleep studies
- Bell Pad Alarm hire for nocturnal enuresis
- This service does not provide psychology or speech autism specific assessments

PLEASE NOTE: All referrals received by Monash Health are triaged by clinicians to determine urgency of referral.

- Patients assessed as having an **urgent** need are offered an appointment within thirty days as assessed by the clinician.
- Patients assessed as having a **non-urgent** need for appointments in clinics where there is no waiting list, are offered an appointments within four months on a "treat in turn basis".
- Patients assessed as having a **non-urgent** need for appointments in clinics that have a waiting list, referrers and patients will be notified of the expected wait times. Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at http://humanservicesdirectory.vic.gov.au/Search.aspx

IMPORTANT:

The following information is mandatory:

Demographic:
- Full name
- Date of birth
- Next of kin
- Postal address
- Landline & mobile number
- Medicare number
- Referring GP details
- Usual GP (if different)
- Interpreter requirements

Clinical:
- Reason for referral
- Duration of symptoms
- Management to date and response to treatment
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Dietary status
- Family history
- Diagnostics as per referral guidelines

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Review July 2017

Neonatal Follow up

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Patient Presentation	Initial GP Work Up	Management Options For GP
▪ Pre term babies (Less than 37 weeks gestational age)	▪ If not already being seen elsewhere, obtain pregnancy and perinatal history of baby and mother and conduct a general physical examination ▪ Plot growth parameters on appropriate growth chart ▪ Assess whether developmental concerns exist ▪ Screen for maternal mental health concerns	▪ Liaise with patient's Maternal and Child Health Nurse ▪ Address maternal depression/anxiety if present

WHEN TO REFER

- All babies born earlier than 37 weeks gestation should have Paediatric follow up at least once

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▪ Term Babies (37- 40 weeks gestational age)	▪ Usual newborn general examination including take a history of pregnancy and perinatal difficulties ▪ Screen for maternal mental health concerns ▪ Plot growth parameters on appropriate growth chart	▪ Liaise with patient's Maternal and Child Health Nurse ▪ Address maternal depression/anxiety if present

WHEN TO REFER

- If have any concerns regarding growth, feeding, development or other issues that are not resolving within the expected time frame

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Developmental concerns

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Patient Presentation

- Concern about child's development, developmental delay

Initial GP Work Up

- Determine which specific domains are delayed eg. gross motor, fine motor, language, or social/emotional
- Refer for hearing/vision testing as part of differential diagnosis and co-morbidities (e.g. vision, hearing, autism spectrum, behaviour problems)
- Standard history and physical exam. Include history from parents /caregivers regarding onset and course of symptoms and family history of similar patterns
- Developmental history (MCH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options For GP

- Refer to allied health professional for an assessment and/or intervention and review within a pre-determined period of time (eg. 3-6 months)
- Refer for Early Childhood Intervention Services if delays identified in 2 or more domains

WHEN TO REFER

- If ongoing concerns about development without known risk factors and after other factors (such as hearing assessment) have been taken into account

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- Challenging behaviour

- Standard history and physical exam. Include history from parents/ caregivers regarding onset and course of symptoms and family history of similar problems
- Consider both internalising and externalising behaviour problems, parenting skills, parental mental health, social factors, and family dysfunction (e.g. abuse) school problems. Consider possibility of co-morbidities e.g. learning disabilities, developmental disorders
- Developmental history (MCH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

- If the behaviour problems are relatively simple, the GP may consider parental education and behaviour modification strategies with review within a pre-determined period of time (eg 3 months) to assess progress
- If the challenging behaviour appears to be specific the GP may consider a referral to a child psychologist for a prescribed course of intervention using the Mental Health Plan
- Referral to child and adolescent mental health services if there is a strong component of mental health concerns to the presentation

WHEN TO REFER

- Significant parent concern
- Problem difficult to define
- Response to simple behavioural measures not effective
- Medication may be considered
- Has co-morbid symptoms that require special assessment or interventions

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Developmental concerns cont.

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Patient Presentation

- Continence Issues - Encopresis / Soiling

Initial GP Work Up

- History of onset, course and pattern of soiling
- Associated history of constipation, wetting
- Developmental history, toilet training history
- Associated behaviour patterns
- Parent and child's attitude to problem
- Dietary history (rarely the main cause)
- Physical exam including spine, abdomen and perineal, perianal area
- Rectal examination is not routinely recommended
- Abdominal x-rays are not required for diagnosis, may be useful if treatment resistant
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options For GP

- Explanation/ demystification of faecal retention and soiling minimise blame and shame
- Behaviour modification diary (regular toileting, star charts, rewards)
- Combination stool softener and stimulant laxative
- Encourage high fibre diet, adequate clear fluids
- Treatment and monitoring often required for months

WHEN TO REFER

- Soiling is prolonged, treatment resistant
- Associated significant behavioural problems
- Soiling associated with day wetting
- Soiling not associated with faecal retention and overflow

Continence Issues - Enuresis / Wetting

- Developmental history, toilet training history
- Associated behaviour patterns
- Parent and child's attitude to problem

Night wetting

- Offer treatment 7yrs or older
- Use diary to measure and monitor
- Explore parenting practices e.g. night fluid restricting, overnight toileting, punitive practices
- Urine microscopy not required unless separate symptoms indicative of UTI
- Assess whether constipation is a problem

Day wetting

- Consider overactive bladder, low awareness bladder sensation, poor attention / concentration
- Exclude UTI with urine microscopy
- Consider constipation

Details of all treatments offered and tried

Copies of other relevant letters should accompany the referral

Refer to the Australian Continence Foundation for GP management

WHEN TO REFER

- Night wetting persistent following failed treatment
- Day wetting persistent after constipation / UTI treated

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Developmental concerns cont.

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Patient Presentation

- Learning difficulties

Initial GP Work Up

- Standard history and physical exam. Include history from parents/ caregivers regarding onset and course of symptoms and family history of similar patterns
- Hearing and vision assessment
- School history
- Consider contributing causes eg. anxiety, family dysfunction
- Consider co-morbidities e.g. ADHD, other behaviour disorders, language disorders, developmental disorders, intellectual disability
- Developmental history (MCH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options For GP

- Refer for cognitive and/or educational testing if suspect intellectual disabilities or specific learning disability
- Depending on local services available, this may be done through the child's school

WHEN TO REFER

- Significant parental concern (PEDS Screening Tool)
- Child not functioning as expected in school
- Cause of learning problems not clear
- Routine school supports e.g. reading recovery, not effective or not sustained
- Previous assessments not well understood, or integrated into school or homework programs
- Child developing anxiety, low self-esteem

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Growth concerns

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Patient Presentation	Initial GP Work Up	Management Options For GP
▪ Failure to thrive	▪ Plot height, weight and head circumference on percentile charts (multiple measurements if available to note trend) ▪ Assess current oral intake and output ▪ Screen for any mental health concerns in the parents ▪ Note any intercurrent illness and relevant past medical history ▪ Standard history and physical exam. Include history from parents /caregivers regarding onset and course of symptoms and family history of similar patterns ▪ Developmental history (MCH notes, child care records, PEDS Screening Tool) ▪ Details of all treatments offered and tried ▪ Copies of other relevant letters should accompany the referral	▪ Provide specific intervention then observe closely over a short period of time and review regularly

WHEN TO REFER

- If child has crossed two percentile curves. If there are known risk factors. If there is possible mental illness in parents. If there are protective issues. If there is parental concern

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▪ Feeding Difficulties	▪ Plot height, weight and head circumference on percentile charts and assess growth progress ▪ Estimate intake vs output ▪ Consider any intercurrent illness and/or relevant past medical history. ▪ Screen for mental illness in parents ▪ Developmental history (MCH notes, child care records, PEDS Screening Tool) ▪ Details of all treatments offered and tried ▪ Copies of other relevant letters should accompany the referral	▪ Refer to maternal and child health nurse for more detailed advice ▪ Provide specific intervention then observe closely over a short period of time and review regularly

WHEN TO REFER

- If child has crossed two percentile curves. If there are known risk factors. If there is possible mental illness in parents. If there are protective issues. If there is parental concern

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▪ Obesity	▪ Plot height, weight and head circumference on percentile charts and assess growth over time if available. ▪ Enquire about lifestyle factors ▪ Developmental history (MCH notes, child care records, PEDS Screening Tool). ▪ Details of all treatments offered and tried. ▪ Copies of other relevant letters should accompany the referral.	▪ Screen for complications of obesity ▪ Provide advice and observe for 6 months if no suggestion of atypical cause.

WHEN TO REFER

- If no improvement despite initial management. If severe obesity or in very young. If medical complications exist. If cause is uncertain

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Other General Paediatric Issues

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Patient Presentation

- Asthma / Atopy (predisposition toward developing certain allergic hypersensitivity reactions)

Initial GP Work Up

- History of allergic disease (e.g. atopic eczema/allergic rhinitis)
- Family history of allergic disease
- History of asthma symptoms
- Severity and pattern - infrequent episodic, frequent episodic, persistent
- Worsening symptoms in pollen season (e.g. October to February)
- Symptoms at night or early morning (e.g. house dust mite)
- Physical examination
- Concurrent allergic rhinitis
- RAST test to assess for specific allergy, if the history indicates (e.g. cat dander, dust mite, grass pollen)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options For GP

Asthma treatment and management:

- Use standard treatment (preventer and reliever)
- Emphasize correct MDI or dry power inhaler technique
- Asthma Action Plan
- First Aid education

Allergen avoidance:

- Only do dust mite avoidance if RAST and history strongly indicate perennial rhinitis and dust mite sensitisation
- No evidence exists that dust mite avoidance works and it is expensive. Sprays do not work. Err on the side of under-recommending

Treat allergic rhinitis:

- Allergic rhinitis can exacerbate asthma symptoms

Medications to avoid:

- Aspirin
- Non-steroidal anti-inflammatory medicines
- Beta blockers
- 'Natural' remedies (e.g. echinacea or royal jelly) that may cause allergic reaction

WHEN TO REFER

- If no improvement despite initial management
- Significant parental concern

- Sleep

- Enquire about lifestyle factors, sleep cycles, disruptions/ siblings
- Developmental history (MCH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

- Encourage parents to develop day and night routines for their neonate to assist with the development of day and night rhythms and the transition to night-time sleeping
- Refer to maternal and child health nurse for more detailed advice

WHEN TO REFER

- If no improvement despite initial management
- Significant parental concern

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Other General Paediatric Issues

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Patient Presentation	Initial GP Work Up	Management Options For GP
Urinary Tract Infection (UTI)	▪ Urine culture - clean catch urine ▪ Renal Ultrasound ▪ Assess bladder function ▪ Assess for constipation Please ensure you have provided all of the above plus ▪ Growth records ▪ Details of all treatments offered and tried ▪ Copies of other relevant letters should accompany the referral	▪ Consider role of prophylactic antibiotics. ▪ Do not arrange a routine VCUG (voiding cystourethrogram)

WHEN TO REFER

- Febrile UTI
- Recurrent afebrile UTI (more than 3 in one year)
- Associated hypertension or can't take blood pressure
- Do not refer if single afebrile UTI over 24months of age with no other findings

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▪ First Seizure	▪ Enquire about development, general health, sleep ▪ Developmental history (MCH notes, child care records, PEDS Screening Tool) ▪ 12 lead ECG to look for arrhythmias. ▪ Details of all treatments offered and tried ▪ Copies of other relevant letters should accompany the referral	▪ Referral initiated ▪ Encourage parents keep diaries of events and video an event if possible ▪ Ensure parents know first aid of a Seizure

WHEN TO REFER

- As per “Management options for GP”

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