NSW Health

Adult Ear, Nose & Throat (ENT) State-wide Referral Criteria for Public Outpatient Services

This document is to be used as a guide for referrers and clinicians in NSW public outpatient services

The aim of SRC is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services.

This document contains ENT SRC for ENT emergencies, ENT presentations out of scope, and the following presenting conditions:

Acknowledgements

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Notes

- ENT SRC sets thresholds for referral, regardless of source, to NSW public ENT and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services, and the expected clinical urgency category based on clinical need
- ENT SRC supports patients to be managed by the most appropriate member(s) of the multidisciplinary care team in the most appropriate setting based on their presenting condition
- ENT SRC are applicable to NSW Local Health Districts and Specialty Health Networks with public ENT and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services that manage the identified presenting conditions
- ENT SRC are applicable where the identified presenting conditions managed by otolaryngologists are delivered in private practice as part of public-private hospital arrangements
- ENT SRC may also be used by a range of specialists in private practice at their own discretion
- ENT SRC does not intend to change eligibility in terms of presenting conditions managed and referral sources accepted for NSW public ENT and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services
- Some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local contextual factors and/or service availability
- Referring health professionals may consider local alternative care options, including private practice, Aboriginal Community Controlled Health Services and/or non-government organisations, where appropriate, for patients seeking to access specialist services

Glossary

The structure for SRC in NSW is divided into the following five criterion.

In some cases, component(s) may not be applicable to each presenting condition. This will be denoted by 'Nil'.

Criterion	Description
Emergency	• Clinical presentations or 'red flags' where referring health professionals should consider redirecting the patient to an Emergency Department or urgent care service, or seeking medical advice (e.g. phone on-call medical practitioner) • These criteria should not be used by referring health professionals to refer to an NSW public specialist outpatient service
Out of scope (not routinely provided)	• Symptoms, conditions and/or presentations that would not routinely be provided by NSW public specialist outpatient services (i.e. could be optimally and safely managed in primary care) • These criteria acknowledge and permit exceptions, where clinically appropriate
Access and prioritisation	• Symptoms, conditions and/or presentations that advise referring health professionals, clinicians, patients and carers suitability for management by NSW public specialist outpatient services • These criteria are classified by expected clinical urgency category and clinically recommended timeframes to be seen for a new outpatient appointment (i.e. Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days) • These criteria are only applicable where NSW public specialist outpatient services exist and manage the identified presenting condition
Required information	• Mandatory information that is to be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category
Additional information (if available)	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

ENT emergencies

Note: ENT emergencies require immediate medical attention and/or intervention to prevent or manage serious harm to a patient. The list of emergency criteria below may not be exhaustive. Please refer to HealthPathways for more information.

Presenting condition	Emergency criteria
Laryngectomy complications (paediatric and adult)	• Any form of airway obstruction and difficulty managing sputum load or clearance • Bleeding • Difficulty breathing • Foreign body • New onset bleeding or shrinkage of laryngectomy stoma (adult only) • Trauma • Voice prosthesis
Tracheostomy complications (paediatric and adult)	• Bleeding • Broken equipment • Dislodgement or any form of obstruction • Foreign body • Trauma
Accidental dislodgement, obstruction of permanent tracheostomy or voice prosthesis (laryngectomy) (adult)	• Accidental dislodgement, obstruction of permanent tracheostomy or voice prosthesis (laryngectomy)
Acute foreign body (adult)	• Button battery (in ear, nose and/or throat) (excludes ear foreign body if not a battery) • Foreign body in airway (including nose) • Ingestion of poisons
Acute neurological change (adult)	• Lower motor neurone facial nerve palsy
Acute trauma or fractures (adult)	• Acute hoarseness associated with laryngeal trauma • Airway compromise post-laryngeal trauma • Nasal fracture • Pinna haematoma • Septal haematoma

Acutely enlarging neck mass (adult)	• Acutely enlarging neck mass with any of the following associated airway symptoms:
	  ○ Drooling
	  ○ Dysphagia
	  ○ Stridor
	• Acutely enlarging neck mass with current symptoms post neck or thyroid surgery

Airway compromise (adult)	• Airway compromise with any of the following (but not associated with trauma or suspected infection):
	  ○ Acute sudden change of breathing
	  ○ Drooling
	  ○ Severe odynophagia
	  ○ Stridor

Allergic rhinitis, nasal congestion or obstruction (adult)	• Nil emergency criteria
Bleeding (adult)	• Haemorrhagic tonsillitis • Post-tonsillectomy haemorrhage • Uncontrolled epistaxis

Recurrent tonsillitis (adult)	• Abscess (e.g. peritonsillar abscess or quinsy)
	• Acute tonsillitis with any of the following:
	  ○ Breathing difficulty
	  ○ Stridor
	  ○ Sudden voice change
	  ○ Systemically unwell
	  ○ Unable to tolerate oral intake
	  ○ Uncontrolled fever

Salivary gland disorders (adult)	• Acute salivary gland inflammation unresponsive to treatment • Airway compromise – stridor, drooling, breathing difficulty, acute or sudden voice change, severe odynophagia • Profound dysphagia – inability to manage secretions • Proven or suspected abscess within the neck (odontogenic, salivary or other deep neck space) or Ludwig's angina • Sialadenitis in immunocompromised patients, or facial nerve palsy • Unilateral facial swelling associated with trismus, swelling in the neck, difficulty in breathing and/or dental sepsis
Sensorineural hearing loss (adult)	• Focal neurological signs or symptoms, including sudden vertigo • Sensorineural hearing loss and associated head trauma • Sudden onset sensorineural hearing loss (unilateral or bilateral) Note: urgent clinical review within emergency department (ideally within 24 hours of onset) and formal audiogram are recommended. Systemic therapy is ideally provided within 1-2 weeks but can be considered for up to 6 weeks following onset of hearing loss.

Severe infection (adult)	• Acute coalescent mastoiditis • Acute tonsillitis with airway obstruction (including quinsy) • Complicated sinusitis (i.e. periorbital cellulitis, frontal sinusitis) • Ear canal oedema or unable to clear discharge (otitis externa) • Epiglottitis • Infection causing airway obstruction or partial obstruction • Ludwig's angina • Necrotising otitis externa (initial diagnosis) • Pinna cellulitis • Supraglottitis • Unilateral sinusitis not responding to oral antibiotics

Thyroid mass (adult)	• Thyroid mass with any of the following:
	  ○ Airway compromise
	  ○ Breathing difficulty
	  ○ Drooling
	  ○ Haemoptysis
	  ○ Severe odynophagia
	  ○ Stridor
	  ○ Sudden increase in size or pain over days to weeks
	  ○ Sudden voice change

Voice disorders (adult)	• Hoarse voice or other acute voice change associated with:
	  ○ Breathing difficulty or stridor
	  ○ Haemoptysis
	  ○ Moderate to severe neck pain
	  ○ Neck or laryngeal trauma
	  ○ Neck swelling
	  ○ Recent thyroid, neck or laryngeal surgery

ENT presentations out of scope

Presenting condition	Out of scope (not routinely provided) criteria
Aesthetic surgery (paediatric and adult)	• Aesthetic surgery
Chronic bilateral tinnitus (paediatric and adult)	• Referral is not indicated unless tinnitus is disabling or associated with changes in hearing loss, aural fullness and/or discharge or vertigo Note: most suitable for outpatient audiological assessment
Hearing aid dispensation (paediatric and adult)	• Routine hearing aid dispensation Note: refer to audiologist directly. Audiologist may suggest referral to ENT specialist following assessment if concerned about medical clearance in preparation for hearing aids
Mild or brief orthostatic dizziness (paediatric and adult)	• Mild or brief orthostatic dizziness
Simple ear drum perforation (paediatric and adult)	• As part of acute otitis media Note: consider referral to ENT specialist if persistent perforation for > 3 months following resolution of infection
Uncomplicated or chronic symmetrical hearing loss (paediatric and adult)	• Routine hearing assessment (audiogram) not provided Note: refer to audiologist directly. Audiologist may suggest referral to ENT specialist following assessment.
Allergic rhinitis, nasal congestion or obstruction (adult)	• Aesthetic concerns • Allergic rhinitis responsive to intranasal corticosteroids • Mild, acute rhinosinusitis
Recurrent tonsillitis (adult)	• Patient is not willing to have surgical treatment • Recurrent tonsillitis where episodes are fewer than described in Category 3 criteria, and no modifying factors are present
Salivary gland disorders (adult)	• Nil out of scope criteria
Sensorineural hearing loss (adult)	• Gradual, symmetrical hearing loss that remains aidable Note: consider referral to audiologist
Thyroid mass (adult)	• Low risk (< 1 cm) thyroid nodules, unless otherwise concerning features • Non-bacterial thyroiditis • Uniform, enlarged gland suggestive of thyroiditis without other symptoms

Voice disorders (adult)	• Hoarseness with complete resolution between episodes, with no other red flag symptoms (see persistent hoarseness symptoms in Category 1) Note: consider referral to speech pathologist

Presenting conditions

Allergic rhinitis, nasal congestion or obstruction (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Nil

Out of scope (not routinely provided)

- Aesthetic concerns
- Allergic rhinitis responsive to intranasal corticosteroids
- Mild, acute rhinosinusitis

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Unilateral nasal obstruction with any of the following:
	  ○ New onset offensive or bloody discharge
	  ○ New onset proptosis or ipsilateral visual changes

Category 2 (clinically recommended to be seen within 90 calendar days)	• Recurrent epistaxis

Category 3
(clinically recommended to be seen within 365 calendar days)
	• Nasal obstruction and any of the following:
	  ○ Bilateral symptoms
	  ○ Persisting polyps despite preliminary course of oral steroids with at least 8 weeks of inhaled corticosteroid
	  ○ Post-trauma
	  ○ Deviated nasal septum
	• Nasal obstruction contributing to inability to use CPAP
	• Allergic rhinitis with failed maximal medical management

Required information

- Reason for referral
- Details of the presenting condition, including onset of symptoms, previous course and outcome of treatment (e.g. systemic and topical medications prescribed)
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Details of any previous ENT surgery
  - Skin prick, RAST or IgE results (allergic rhinitis)
  - CT scan (paranasal sinuses) results or reports
  - Location and test date of investigations

Additional information (if available)

- Other specialist referral assessment or report (e.g. respiratory, sleep study, immunology)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Recurrent tonsillitis (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Abscess (e.g. peritonsillar abscess or quinsy)
- Acute tonsillitis with any of the following:
  - Breathing difficulty
  - Stridor
  - Sudden voice change
  - Systemically unwell
  - Unable to tolerate oral intake
  - Uncontrolled fever

Out of scope (not routinely provided)

- Patient is not willing to have surgical treatment
- Recurrent tonsillitis where episodes are fewer than described in Category 3 criteria, and no modifying factors are present

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Abnormally appearing or asymmetrical tonsils with:
	  ○ Drenching night sweats in the absence of infection
	  ○ Unexplained weight loss (≥ 10% of body weight over 3 months)
	• Suspected unilateral tonsil mass or ulcer
	Note: include if recurrent tonsilitis is associated with cervical lymphadenopathy

Category 2 (clinically recommended to be seen within 90 calendar days)	• Severe complications associated with infection (e.g. febrile convulsion, neurological sequelae)

Category 3
(clinically recommended to be seen within 365 calendar days)
	• Chronic or recurrent infection with fever or malaise, decreased oral intake and any of the following:
	  ○ ≥ 7 episodes in the last 12 months
	  ○ ≥ 5 episodes per year in the last 24 months
	  ○ ≥ 3 episodes per year in the last 36 months
	  ○ Sleep apnoea due to tonsillar hypertrophy
	  ○ Tonsillar concretions with halitosis
	  ○ Absent from work, university or college for 4 weeks in a year due to tonsillitis
	  ○ ≥ 1 episode of quinsy

Required information

- Reason for referral
- Details of the presenting condition, including impact on activities of daily living and/or quality of life
- Provisional diagnosis

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Smoking history
    - Tonsillitis episode history

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Salivary gland disorders (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Acute salivary gland inflammation unresponsive to treatment
- Airway compromise – stridor, drooling, breathing difficulty, acute or sudden voice change, severe odynophagia
- Profound dysphagia – inability to manage secretions
- Proven or suspected abscess within the neck (odontogenic, salivary or other deep neck space) or Ludwig's angina
- Sialadenitis in immunocompromised patients, or facial nerve palsy
- Unilateral facial swelling associated with trismus, swelling in the neck, difficulty in breathing and/or dental sepsis

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Confirmed or suspected tumour or hard mass in the salivary glands • Salivary gland mass associated with facial nerve weakness, trismus and/or involvement or erosion of external auditory canal • Abnormal imaging where malignancy is suspected • Sudden or rapid change in a previously benign salivary gland mass • Cytological atypia or malignancy on fine needle aspirate (FNA)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Recurrent sialadenitis • Confirmed pleomorphic adenoma
Category 3 (clinically recommended to be seen within 365 calendar days)	• Symptomatic salivary stones and/or recurrent symptoms that respond to non-invasive treatment • Asymptomatic salivary gland stones • Confirmed Warthin's tumour that is symptomatic and/or other benign salivary gland tumours

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their frequency, severity and previous treatment
- Provisional diagnosis

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - History of skin cancer removal from the head and neck region
    - Smoking history (for Warthin's tumour)
    - Family history of relevant autoimmune conditions (systemic lupus erythematosus, Sjogren's syndrome)
    - Examination findings at time of referral (including site of mass)
    - Ultrasound and/or CT results (include copy of result, test location and date)
    - Fine needle aspirate (FNA) biopsy results (include copy of result, test location and date) (as appropriate)

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Sensorineural hearing loss (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Focal neurological signs or symptoms, including sudden vertigo
- Sensorineural hearing loss and associated head trauma
- Sudden onset sensorineural hearing loss (unilateral or bilateral)
  Note: urgent clinical review within emergency department (ideally within 24 hours of onset) and formal audiogram are recommended. Systemic therapy is ideally provided within 1-2 weeks but can be considered for up to 6 weeks following onset of hearing loss.

Out of scope (not routinely provided)

- Gradual, symmetrical hearing loss that remains aidable
  Note: consider referral to audiologist

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Hearing loss associated with ototoxic medicine(s) • New sensorineural hearing loss confirmed by diagnostic audiology assessment in the presence of risk factors (e.g. autoimmune conditions)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Longstanding, asymmetrical sensorineural hearing loss confirmed by diagnostic audiology assessment

Required information

- Reason for referral
- Details of the presenting conditions, including description of hearing loss or change in hearing (onset, duration, timing)
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Family history of hearing loss
  - Serial audiograms with ear and bone conduction, and tympanometry
  - Speech discrimination assessment findings

Additional information (if available)

- Results of MRI (brain and IAM)
- Other specialist assessment or report (e.g. immunology)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)

- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Thyroid mass (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Thyroid mass with any of the following:
  - Airway compromise
  - Breathing difficulty
  - Drooling
  - Haemoptysis
  - Severe odynophagia
  - Stridor
  - Sudden increase in size or pain over days to weeks
  - Sudden voice change

Out of scope (not routinely provided)

- Low risk (< 1 cm) thyroid nodules, unless otherwise concerning features
- Non-bacterial thyroiditis
- Uniform, enlarged gland suggestive of thyroiditis without other symptoms

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Cytologically confirmed malignancy (Bethesda VI) • Cytologic atypia or cytology suspicious for neoplasm or malignancy • Intermediate to high suspicion of malignancy on thyroid ultrasound where fine needle aspirate (FNA) cannot be performed promptly (TI RADS 4-5) • Multinodular goitre or thyroid enlargement with symptoms of moderate to severe compression (e.g. dyspnoea, stridor, exercise intolerance, dysphagia, thoracic outlet obstruction – Pemberton's sign) • Cervical lymphadenopathy associated with a thyroid mass (central or lateral neck)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Thyroid nodule > 4 cm regardless of imaging and cytology findings • Increase in size of previously identified thyroid nodule > 1 cm • Repeat non-diagnostic FNA cytology of a thyroid nodule • Thyroid nodule with FNA biopsy showing Bethesda III
Category 3 (clinically recommended to be seen within 365 calendar days)	• Multinodular goitre or generalised thyroid enlargement without compressive symptoms or with symptoms of mild compression (e.g. minor exercise intolerance, mild dysphagia) • Recurrent thyroid cysts (non-obstructive)

Required information

- Reason for referral
- Details of the presenting condition, including symptom history and their duration
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Physical examination findings
  - Thyroid stimulating hormone (TSH) and free thyroxine (T4) results
  - Diagnostic ultrasound and fine needle aspirate (FNA) biopsy results (include copy of results, test location and date)

Additional information (if available)

- Personal or family history of thyroid cancer or familial endocrine neoplasia syndromes
- Previous head and/or neck malignancy
- Previous head and/or neck radiation treatment
- Whether the patient is currently taking antiplatelet or anticoagulant medication
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Voice disorders (adult)

Emergency

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice via phone to on-call consultant or registrar.

- Hoarse voice or other acute voice change associated with:
  - Breathing difficulty or stridor
  - Haemoptysis
  - Moderate to severe neck pain
  - Neck swelling
  - Neck or laryngeal trauma
  - Recent thyroid, neck or laryngeal surgery

Out of scope (not routinely provided)

- Hoarseness with complete resolution between episodes, with no other red flag symptoms (see persistent hoarseness symptoms in Category 1)
  Note: consider referral to speech pathologist

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Persistent hoarseness (> 4 weeks) with any of the following:
	  ○ Dysphagia
	  ○ Associated throat or ear pain
	  ○ Neck lump
	  ○ Haemoptysis
	  ○ Past history of head and neck cancer (especially in smokers)
	• Recent change to voice and persistent hoarseness which fails to resolve in 4 weeks and includes a background history of any of the following:
	  ○ Current smoking
	  ○ Excessive alcohol intake
	  ○ Recent intubation
	• Persistent hoarseness in a patient with a known gastric, lung or ENT malignancy

Category 2 (clinically recommended to be seen within 90 calendar days)	• Patient relies on their voice for profession, and symptoms have not improved following period of speech pathology management
Category 3 (clinically recommended to be seen within 365 calendar days)	• Persistent hoarseness (> 4 weeks) and/or change in voice quality which fails to resolve in 4 weeks and in the absence of risk factors or red flag symptoms Note: consider referral to speech pathologist

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration

- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - If the patient is a professional voice user
    - Smoking history
    - Alcohol intake history
    - Head and neck cancer history

Additional information (if available)

- Speech pathology assessment or report
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)