NSW Health

Paediatric 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:

- ENT emergencies
- ENT presentations out of scope
- Allergic rhinitis, nasal congestion or obstruction (paediatric)
- Obstructive sleep apnoea or sleep disordered breathing (paediatric)
- Otitis media (with effusion and chronic or recurrent) (paediatric)
- Recurrent tonsilitis (paediatric)
- Salivary gland disorders (paediatric)
- Sensorineural hearing loss (paediatric)
- Voice disorders (paediatric)

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Significant contributors: Dr Niall Jefferson (Clinical Lead), Dr Hannah North (Clinical Lead), Dr Nicholas Jufas, Dr Julia Crawford, Dr Sergios Latis, Richard Davies, Elissa Haddrick, Jacob Pogson, Alison Marshall, Jana Carr, Jessica Muscat, Eura (Ha Eun) Lim, Dr Campbell Howitt, Dr Kanav Malhotra, Dr Ying Wu

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 or obstruction of permanent tracheostomy (paediatric)	• Accidental dislodgement or obstruction of permanent tracheostomy
Acute foreign body (paediatric)	• 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 (paediatric)	• Lower motor neurone facial nerve palsy
Acute trauma or fractures (paediatric)	• Acute hoarseness associated with laryngeal trauma • Airway compromise post-laryngeal trauma • Nasal fracture • Septal haematoma

Acutely enlarging neck mass (paediatric)	• 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 (paediatric)	• Airway compromise with any of the following (but not associated with trauma or suspected infection):
	  ○ Acute, sudden change
	  ○ Breathing difficulty
	  ○ Drooling
	  ○ Severe odynophagia
	  ○ Stridor

Allergic rhinitis, nasal congestion or obstruction (paediatric)	• Nil emergency criteria
Bleeding (paediatric)	• Airway bleeding • Post-tonsillectomy bleeding • Uncontrolled epistaxis

Obstructive sleep apnoea or sleep disordered breathing (paediatric)	• Acute, sudden voice change
	• Acutely enlarging neck mass with any of the following associated airway symptoms:
	  ○ Drooling
	  ○ Dysphagia
	  ○ Stridor
	• Airway compromise with or without severe stridor, drooling or respiratory distress
	• Severe odynophagia
	• Witnessed cyanosis or severe apnoea

Otitis media (with effusion and chronic or recurrent) (paediatric)	• Suspected or confirmed complication of acute suppurative otitis media (ASOM) – i.e. mastoiditis (proptosis of pinna), meningitis, associated neurological signs (e.g. facial nerve palsy, profound vertigo and/or sudden deterioration in sensorineural hearing)
Recurrent tonsillitis (paediatric)	• Epiglottitis or bacterial tracheitis • Haemorrhagic tonsillitis • Peritonsillar cellulitis or abscess • Severe dehydration • Swelling causing acute upper airway obstruction (e.g. stridor or respiratory distress) • Toxic appearance (e.g. pale or mottled skin, cool extremities, weak cry, grunting, rigors, decreased responsiveness, or signs of sepsis in children) • Unable to tolerate oral intake
Salivary gland disorders (paediatric)	• Acute salivary gland inflammation unresponsive to treatment • Airway compromise with or without severe stridor, drooling or breathing difficulty

	• Profound dysphagia – inability to manage secretions • Salivary abscess associated with swelling in the neck and/or breathing difficulty • Sialadenitis in immunocompromised patients, or facial nerve palsy
Sensorineural hearing loss (paediatric)	• 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 formal audiogram is 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 (paediatric)	• Abscess or haematoma (e.g. peritonsillar, parapharyngeal – quinsy, salivary, neck or retropharyngeal abscess) • 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) • 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
Voice disorders (paediatric)	• Hoarseness lasting more than 4 weeks without upper respiratory tract infection (URTI) symptoms • New onset hoarse voice and any airway obstructive symptoms • Unexplained hoarseness lasting > 4 weeks with risk factors for malignancy

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 (paediatric)	• Nil out of scope criteria
Obstructive sleep apnoea or sleep disordered breathing (paediatric)	• Nil out of scope criteria
Otitis media (with effusion and chronic or recurrent) (paediatric)	• Middle ear effusion in one ear for < 6 months or both ears for < 3 months
Salivary gland disorders (paediatric)	• Nil out of scope criteria
Recurrent tonsillitis (paediatric)	• Enlarged tonsils with no recurrent tonsillitis as described in Category 2 and 3 criteria, and/or no evidence of obstructive sleep disordered breathing • Recurrent tonsillitis where episodes are fewer than described in Category 2 and 3 criteria, and no modifying factors are present
Sensorineural hearing loss (paediatric)	• Subjective hearing loss with normal audiogram Note: follow SWISH referral guidelines for hearing loss identified in neonates

Voice disorders (paediatric)	• Nil out of scope criteria

Presenting conditions

Allergic rhinitis, nasal congestion or obstruction (paediatric)

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)	
• Nil	
Access and prioritisation	
Category 1 (clinically recommended to be seen within 30 calendar days)	• Unilateral nasal obstruction with offensive and/or bloody discharge • Significant nasal obstruction in an infant with failure to thrive
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nasal obstruction contributing to symptomatic nasal obstruction with failed maximal medical management or septal deviation • Allergic rhinitis with failed maximal medical management due to poor patient compliance
Required information	
• Reason for referral • Details of the presenting condition • Provisional diagnosis • Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically medical management to date	
Additional information (if available)	
• RAST or IgE results (allergic rhinitis) • 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 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)	

Obstructive sleep apnoea or sleep disordered breathing (paediatric)

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, sudden voice change
- Acutely enlarging neck mass with any of the following associated airway symptoms:
  - Drooling
  - Dysphagia
  - Stridor
- Airway compromise with or without severe stridor, drooling or respiratory distress
- Severe odynophagia
- Witnessed cyanosis or severe apnoea

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Polysomnographic evidence of severe obstructive sleep apnoea with continuous positive airway pressure (CPAP) intolerance (despite effort) and significant, uncontrolled desaturations or cardiovascular compromise

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Severe obstructive sleep apnoea confirmed on polysomnography (PSG)
	• Obstructive sleep apnoea with faltering growth (failure to thrive)
	• Prolonged history (> 3 months) of an obstructive breathing pattern persisting after trial of nasal steroids with all of the following present:
	  ○ Parental report or video evidence of obstruction
	  ○ Significant daytime behavioural impacts
	  ○ Witnessed clinical apnoea or gasping episodes

Category 3 (clinically recommended to be seen within 365 calendar days)	• Mild to moderate sleep disordered breathing or obstructive sleep apnoea • Obstructive sleep disordered breathing following trial of nasal steroids for ≥ 4 weeks • Sleep disordered breathing and underlying developmental or behavioural issues • Snoring and/or significant sleep fragmentation and sleep related behavioural concerns • Persistent bed wetting (enuresis) • Tooth grinding (bruxism) following dental review and exclusion of other causes

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Tonsillar hypertrophy grading scale (Brodsky scale)
    - Presence of a co-existing craniofacial abnormality

Additional information (if available)

- Paediatric Epworth or pictorial Sleepiness Scale
- Recent paediatric polysomnography (PSG)
- Video evidence of child with sleep disordered breathing
- Total OSA-5 score
- 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 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)

Otitis media (with effusion and chronic or recurrent) (paediatric)

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.

- Suspected or confirmed complication of acute suppurative otitis media (ASOM) – i.e. mastoiditis (proptosis of pinna), meningitis, associated neurological signs (e.g. facial nerve palsy, profound vertigo and/or sudden deterioration in sensorineural hearing)

Out of scope (not routinely provided)

- Middle ear effusion in one ear for < 6 months or both ears for < 3 months

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Confirmed or suspected structural damage to the tympanic membrane (e.g. significant retraction, cholesteatoma)
	• Effusion and any of the following:
	  ○ Speech delay, educational handicap and/or Aboriginal Torres Strait Islander descent
	  ○ Structural or medical comorbidities (e.g. cleft palate, craniofacial abnormalities, diabetes, sensorineural hearing loss) and lasting > 3 months with audiometry showing significant bilateral or unilateral conductive hearing loss (≥ 30 dB in better ear)
	• Perforated tympanic membrane and any of the following:
	  ○ Ongoing pain
	  ○ Persistent drainage from the middle ear for > 6 weeks despite topical antibiotics
	  ○ Significant hearing loss ≥ 45 dB in better ear
	• ≥ 3 episodes of acute otitis media within 6 months
	• ≥ 4 episodes of acute otitis media within 12 months and hearing loss

Category 3 (clinically recommended to be seen within 365 calendar days)	• Chronic otitis media with effusion (glue ear) for 3 months with no significant hearing loss and no impact on speech and language development • Perforation not healed in 6-12 months, and a hearing loss > 25 dB, or if other significant risk factors (e.g. speech delay or other disability) are present • Dry perforation persists > 6 months in a child aged ≥ 8 years for consideration of tympanoplasty • Middle ear dysfunction (including Eustachian tube dysfunction) affecting one or both ears for > 6 months with both of the following: ○ Impact on speech and language development

	○ Pre-existing disability, or high risk of speech, language or learning disability

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Medical management to date
  - Most recent diagnostic audiology assessment results (audiogram, tympanometry and/or otoscopic examination)

Additional information (if available)

- Speech pathology assessment against normal developmental milestones
- Family history of hearing loss
- Previous audiology assessment results
- 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 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 (paediatric)

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.

- Epiglottitis or bacterial tracheitis
- Haemorrhagic tonsillitis
- Peritonsillar cellulitis or abscess
- Severe dehydration
- Swelling causing acute upper airway obstruction (e.g. stridor or respiratory distress)
- Toxic appearance (e.g. pale or mottled skin, cool extremities, weak cry, grunting, rigors, decreased responsiveness, or signs of sepsis in children)
- Unable to tolerate oral intake

Out of scope (not routinely provided)

- Enlarged tonsils with no recurrent tonsillitis as described in Category 2 and 3 criteria, and/or no evidence of obstructive sleep disordered breathing
- Recurrent tonsillitis where episodes are fewer than described in Category 2 and 3 criteria, and no modifying factors are present

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Suspected malignancy
	• Abnormally appearing tonsils with any of the following present:
	  ○ Drenching night sweats in the absence of infection
	  ○ Unexplained weight loss (> 10% of body weight over 3 months)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Ulceration and/or recurrent unilateral enlargement, with or without lymphadenopathy • Complicated tonsillitis (e.g. multiple medication allergies) • ≥ 1 episode of quinsy in the context of recurrent tonsillitis • ≥ 2 episodes of quinsy without a history of recurrent tonsillitis • Severe complications associated with infection (e.g. febrile convulsion, neurological sequelae)

Category 3
(clinically recommended to be seen within 365 calendar days)
	• Recurrent tonsillitis with:
	  ○ ≥ 7 episodes in the last 12 months
	  ○ ≥ 4 - 5 episodes per year in the last 24 months
	  ○ ≥ 3 episodes per year in the last 36 months
	• Episodes of acute tonsillitis are significantly affecting schooling or employment
	• Associated signs of sleep disordered breathing (e.g. abnormal respiratory patterns including presence of apnoea or hypopnoea, snoring, restless sleep)
	• Swallowing difficulties causing pathological weight loss

	• Recurrent tonsillitis associated with PANDAS, PFAPA and/or Aphthous stomatitis for consideration for tonsillectomy • Gagging of food • Tonsil stones and/or halitosis

Required information

- Reason for referral
- Details of the presenting condition, including number, timeframe and severity of previous episodes of quinsy and acute tonsillitis
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Medical management to date
    - Time off school or work
    - Symptoms of obstructive sleep apnoea

Additional information (if available)

- Epstein-Barr virus (EBV) serology or monospot results
- Full blood count (FBC) results
- 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 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 (paediatric)

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 with or without severe stridor, drooling or breathing difficulty
- Profound dysphagia – inability to manage secretions
- Salivary abscess associated with swelling in the neck and/or breathing difficulty
- Sialadenitis in immunocompromised patients, or facial nerve palsy

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 • Abnormal imaging where malignancy is suspected • Acute salivary gland inflammation which fails to respond to oral antibiotics within 1 week
Category 2 (clinically recommended to be seen within 90 calendar days)	• Pleomorphic adenomas that have been previously investigated and are not growing • Symptomatic salivary stones with recurrent symptoms unresponsive to treatment
Category 3 (clinically recommended to be seen within 365 calendar days)	• Asymptomatic salivary stones • Recurrent juvenile parotitis

Required information

- Reason for referral
- Details of the presenting condition, including history of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Examination findings at time of referral (including site of mass)
    - Fine needle aspirate (FNA) results (as appropriate)
    - M/C/S results for sialadenitis (as appropriate)
    - Ultrasound results

Additional information (if available)

- CT scan results
- 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 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 (paediatric)

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)

- Subjective hearing loss with normal audiogram
  Note: follow SWISH referral guidelines for hearing loss identified in neonates

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Sensorineural hearing loss associated with ototoxic medicine(s) • Sensorineural hearing loss confirmed by diagnostic audiology assessment refractory to systemic steroids (i.e. incomplete resolution of hearing loss)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Gradual, longstanding or pre-existing sensorineural hearing loss confirmed by diagnostic audiology assessment

Required information

- Reason for referral
- Details of the presenting condition, 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 audiogram (with bone conduction)

Additional information (if available)

- Results of MRI (brain and IAM)
- If the patient is at increased risk of falling
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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 (paediatric)

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.

- Hoarseness lasting more than 4 weeks without upper respiratory tract infection (URTI) symptoms
- New onset hoarse voice and any airway obstructive symptoms
- Unexplained hoarseness lasting > 4 weeks with risk factors for malignancy

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Preceding neck trauma with persistent dysphonia • Recent onset dysphonia associated with significant dysphagia or weight loss • Dysphonia associated with significant increased work of breathing (e.g. stridor, accessory muscle use)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Suspicion of papilloma, thrush or vocal cord palsy • > 4 weeks of moderate to severe dysphonia and voice loss • > 4 weeks and not associated with an upper respiratory tract infection (URTI) • Persistent symptoms (> 4 weeks) despite adequate voice rest, not associated with an URTI, and without risk factors for malignancy • Persistent dysphonia and associated cough for > 8 weeks unresponsive to medical therapy with associated concerning clinical features (e.g. neck pain, increased work of breathing, significant vocal fatigue)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Persistent dysphonia and associated cough for > 8 weeks unresponsive to medical therapy without associated concerning clinical features (e.g. neck pain, increased work of breathing, significant vocal fatigue)

Required information

- Reason for referral
- Details of the presenting condition including duration of symptoms and medical management to date
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)

Additional information (if available)

- Speech pathology assessment results
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)