NSW Health

Paediatric Gastroenterology 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 State-wide Referral Criteria (SRC) is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services.

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

Acknowledgements

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Notes

- Gastroenterology SRC sets thresholds for referral, regardless of source, to NSW public gastroenterology and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services, and the expected clinical urgency category based on clinical need
- Gastroenterology 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
- Gastroenterology SRC are applicable to NSW Local Health Districts and Specialty Health Networks with public gastroenterology and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services that manage the identified presenting conditions
- Gastroenterology SRC are applicable where the identified presenting conditions managed by paediatric gastroenterologists and general, colorectal or upper gastrointestinal surgeons are delivered in private practice as part of public-private hospital arrangements
- Gastroenterology SRC may also be used by a range of specialists in private practice at their own discretion
- Gastroenterology SRC does not intend to change eligibility in terms of presenting conditions managed and referral sources accepted for NSW public gastroenterology 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

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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

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Gastroenterological emergencies

Note: Gastroenterological 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

Abdominal pain (paediatric)	• Acute, severe abdominal pain for surgical review:
	  ○ Peritonitis, infarction or obstruction (e.g. rigid abdomen, guarding, pain out of proportion to clinical signs)
	  ○ Suspected bowel obstruction – bilious vomiting, significant distention, lack of passage of flatus
	  ○ Suspected ectopic pregnancy, ovarian torsion, or testicular torsion
	  ○ Suspected appendicitis
	  ○ Acute inflammatory condition with systemic signs of sepsis requiring intravenous antibiotics, urosepsis, gynaecological sepsis, cholecystitis
	  ○ Abdominal pain associated with acutely irreducible hernia
	• Shock or sepsis

Altered bowel habit (paediatric)	• Acute severe colitis (> 6 bloody bowel motions per 24 hours) • Dehydration unable to be managed at home • Suspected bowel obstruction – bilious vomiting, significant distention, lack of passage of flatus, obstipation
Coeliac disease (paediatric)	• Nil emergency criteria
Fever in post-liver transplant or other immune suppressed patients (paediatric)	• Fever in post-liver transplant or other immune suppressed patients (e.g. inflammatory bowel disease on biologics, immunomodulators, steroids, anti-rejection medications)
Gastrointestinal bleeding (paediatric)	• Acute haematemesis or melaena • Acute lower gastrointestinal bleeding in large volume or with haemodynamic compromise

Inflammatory bowel disease (suspected or known) (paediatric)	• Suspected or known inflammatory bowel disease with severe abdominal pain and/or bloody diarrhoea, and any of the following features:
	  ○ Fever
	  ○ Haemodynamic compromise
	  ○ Suspected megacolon

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	○ Suspected bowel perforation ○ Bowel obstruction ○ Abscess (abdominal or perianal) ○ Haemoglobin < 90 g/L
Liver dysfunction (paediatric)	• Acute liver failure (e.g. INR > 1.5 and encephalopathy or INR ≥ 2, in the absence of pre-existing liver disease) • Acute paracetamol toxicity Note: referral to paediatrician is indicated if no liver synthetic dysfunction. • Chronic liver failure with fever or sepsis • Jaundice with confusion • Newborn with persistent (> 6 weeks), severe, recurrent unconjugated hyperbilirubinemia (despite phototherapy) Note: phone on-call gastroenterologist for advice. • Post-transplant jaundice with fever or sepsis • Sudden onset, obstructive jaundice
Nutritional and weight concerns (paediatric)	• Acute onset vomiting and/or diarrhoea in the context of dehydration unable to be managed hydration at home and/or electrolyte disturbances
Upper gastrointestinal dysfunction (paediatric)	• Caustic ingestion • Dysphagia with obstruction from food • Suspected or known oesophageal foreign body (especially button battery or > 1 magnet)

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Gastroenterological presentations out of scope

Presenting condition	Out of scope (not routinely provided)
Abdominal pain (paediatric)	• Non-tertiary referrals for chronic abdominal pain without concerning features listed in the 'Emergency' and 'Access and prioritisation' criteria • Second opinions for conditions already seen by the same specialty
Altered bowel habit (paediatric)	• Allergic colitis • Non-tertiary referrals for chronic constipation and encopresis • Positive stool multiplex PCR for infection • Self-limiting diarrhoea < 6 weeks
Coeliac disease (paediatric)	• Normal coeliac serology (regardless of HLA DQ2 or DQ8 typing)
Failure to thrive in the absence of specific gastrointestinal symptoms and negative coeliac serology (paediatric)	• Failure to thrive in the absence of specific gastrointestinal symptoms and negative coeliac serology
Failure to thrive in the context of inadequate energy intake (paediatric)	• Failure to thrive in the context of inadequate energy intake Note: arrange for a paediatric dietitian referral for advice on nutrition support to optimise growth.
Gastrointestinal bleeding (paediatric)	• Non-significant haematochezia (i.e. small, fresh rectal bleeding on wiping) responsive to trial of laxatives • Thriving infant with minor rectal bleeding (i.e. food protein-induced allergic proctocolitis) Note: referrals from paediatricians for allergic proctocolitis remain in-scope.
Helicobacter pylori infection in the absence of dyspeptic symptoms or unexplained iron deficiency anaemia (paediatric)	• Helicobacter pylori infection in the absence of dyspeptic symptoms or unexplained iron deficiency anaemia
Inflammatory bowel disease (suspected or known) (paediatric)	• Bloody diarrhoea in the presence of bacterial infection found on stool multiplex PCR
Liver dysfunction (paediatric)	• Hepatitis A with no coagulopathy that is able to have follow-up in the community • Sonographic fatty liver with normal liver function tests and normal liver and spleen size, in a child who has a weight and BMI > 85th centile as per age and sex appropriate centile chart Note: child would benefit from dietitian or weight management referral in the first instance.

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Nutritional and weight concerns (paediatric)	• Anaemia or iron deficiency secondary to haematological, renal, dietary, physiological or gynaecological cause • Intentional weight loss or body dysmorphia • Isolated low serum ferritin without anaemia, nutritional or weight concerns • Normochromic, normocytic anaemia with normal iron studies • Weight loss in the neonatal period Note: referral should be made to paediatrician.
Parasitic infection with Blastocystis hominis and Dientamoeba fragilis (paediatric)	• Parasitic infection with Blastocystis hominis and Dientamoeba fragilis
Rectal bleeding (small volume) in the setting of formed stools in an otherwise well child (paediatric)	• Rectal bleeding (small volume) in the setting of formed stools in an otherwise well child Note: consider 6-week trial of appropriate stool softener. If bleeding persists despite this trial, referral should be made.
Resolved iron deficiency with 3-month trial of adequate iron supplementation (paediatric)	• Resolved iron deficiency with 3-month trial of adequate iron supplementation (paediatric) Note: consider coeliac screening and holotranscobalamin if unresolved.
Upper gastrointestinal dysfunction (paediatric)	• < 4 weeks of vomiting • Infantile reflux or colic

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Presenting conditions

Abdominal pain (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, severe abdominal pain for surgical review:
  ○ Peritonitis, infarction or obstruction (e.g. rigid abdomen, guarding, pain out of proportion to clinical signs)
  ○ Suspected bowel obstruction – bilious vomiting, significant distention, lack of passage of flatus
  ○ Suspected ectopic pregnancy, ovarian torsion, or testicular torsion
  ○ Suspected appendicitis
  ○ Acute inflammatory condition with systemic signs of sepsis requiring intravenous antibiotics, urosepsis, gynaecological sepsis, cholecystitis
  ○ Abdominal pain associated with acutely irreducible hernia
• Shock or sepsis

Out of scope (not routinely provided)
• Non-tertiary referrals for chronic abdominal pain without concerning features listed in the 'Emergency' and 'Access and prioritisation' criteria • Second opinions for conditions already seen by the same specialty

Access and prioritisation	

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Recurrent abdominal pain with any of the following concerning features:
	  ○ Faltering growth (weight loss ≥ 2 weight centiles)
	  ○ Iron deficiency anaemia with Hb < 90
	  ○ Elevated inflammatory markers (raised platelet count, C-reactive protein, erythrocyte sedimentation rate and/or reduced albumin) if infection excluded (stool MCS or PCR negative)
	  ○ Tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
	  ○ Associated, persistent bloody diarrhoea > 2 weeks and infection excluded

Category 2 (clinically recommended to be seen within 90 calendar days)	• Abdominal pain with iron deficiency anaemia • Abdominal pain with associated persistent non-bloody and non-infectious diarrhoea for > 4 weeks • Tertiary referrals for abdominal pain for > 8 weeks without concerning features Note: referral should be made from paediatrician or paediatric surgeon.
Category 3 (clinically recommended to be	• Nil

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seen within 365 calendar days)	

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), including specifically:
    - 'Blue Book', growth charts or any recent growth measurements
    - Current weight and length or height
    - Weight loss (amount and timeframe)
    - C-reactive protein (CRP)
    - Erythrocyte sedimentation rate (ESR)
    - Full blood count (FBC)
    - Iron studies
    - Liver function test results
    - Coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA)
    - Stool MCS, PCR and microscopy

Additional information (if available)

- Paediatrician report
- Previous investigations and reports of presenting abdominal pain (e.g. endoscopy, radiological reports)
- Faecal calprotectin result if inflammatory bowel disease suspected (in children aged ≥ 4 years)
- 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)

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Altered bowel habit (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, severe colitis (> 6 bloody bowel motions per 24 hours)
- Dehydration unable to be managed at home
- Suspected bowel obstruction (bilious vomiting, significant distention, lack of passage of flatus, obstipation)

Out of scope (not routinely provided)

- Allergic colitis
- Non-tertiary referrals for chronic constipation and encopresis
- Positive stool multiplex PCR for infection
- Self-limiting diarrhoea < 6 weeks

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Persistent diarrhoea (bloody or non-bloody) > 4 weeks with any of the following features:
	  ○ Negative stool multiplex PCR for infection
	  ○ Faltering growth (weight loss of ≥ 2 weight centiles)
	  ○ Elevated inflammatory markers (raised platelet count, C-reactive protein, erythrocyte sedimentation rate and/or reduced albumin)
	  ○ Tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
	  ○ Elevated faecal calprotectin (> 100 mcg/g)
	
	Note: faecal calprotectin levels can be elevated in healthy, pre-school aged children and should be interpreted with caution

Category 2 (clinically recommended to be seen within 90 calendar days)	• Persistent diarrhoea > 4 weeks without any of the above features
Category 3 (clinically recommended to be seen within 365 calendar days)	• Tertiary referral (i.e. paediatrician or paediatric surgeon) for treatment resistant constipation or encopresis

Required information

- Reason for referral
- Details of the presenting condition including duration of symptoms and medical management to date
- Provisional diagnosis

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- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - ‘Blue Book’, growth charts or any recent growth measurements
    - Current weight and length or height
    - Weight loss (amount and timeframe)
    - C-reactive protein (CRP)
    - Erythrocyte sedimentation rate (ESR)
    - Faecal multiplex PCR result
    - Faecal calprotectin result (in children aged ≥ 4 years with diarrhoea > 4 weeks)
    - Full blood count (FBC)
    - Iron studies
    - Liver function test results
    - Coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA)

Additional information (if available)

- Previous investigations and reports (e.g. endoscopy, radiological reports)
- 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)

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Coeliac disease (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)

- Normal coeliac serology (regardless of HLA DQ2 or DQ8 typing)

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Suspected coeliac disease with any of the following:
	  ○ Tissue transglutaminase IgA (TTG IgA) > 10 x upper limit normal (ULN)
	  ○ Iron deficiency anaemia
	  ○ Faltering growth (weight loss of ≥ 2 weight centiles)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Suspected coeliac disease with tissue transglutaminase IgA (TTG IgA) 2-10 x ULN • Suspected coeliac disease in the presence of IgA deficiency (< 0.2 g/L)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Known coeliac disease for routine follow-up

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:
  - ‘Blue Book’, growth charts or any recent growth measurements
  - Weight loss (amount and timeframe)
  - Tissue transglutaminase IgA (TTG IgA) on gluten-containing diet for > 6 weeks
  - Total IgA

    Note: continue gluten-containing diet until initial review or withdraw gluten and advise patient that reintroduction of gluten may be required for further testing.

Additional information (if available)

- Family history of coeliac disease and/or autoimmune disease
- Full blood count (FBC)
- Iron studies
- Endomysial antibodies IgA
- If the patient identifies as Aboriginal and/or Torres Strait Islander

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- 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)

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Gastrointestinal bleeding (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 haematemesis or melaena
- Acute lower gastrointestinal bleeding in large volume or with haemodynamic compromise

Out of scope (not routinely provided)

- Non-significant haematochezia (i.e. small, fresh rectal bleeding on wiping) responsive to trial of laxatives
- Thriving infant with minor rectal bleeding (i.e. food protein-induced allergic proctocolitis)
  Note: referrals from paediatricians for allergic proctocolitis remain in-scope.

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Persistent haematemesis, melaena or rectal bleeding with any of the following features:
	  ○ Faltering growth (weight loss of ≥ 2 weight centiles)
	  ○ Iron deficiency anaemia
	  ○ Persistent diarrhoea (bloody or non-bloody) > 6 weeks
	  ○ Elevated inflammatory markers (raised platelet count, C-reactive protein, erythrocyte sedimentation rate and/or reduced albumin)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Persistent haematemesis, melaena or rectal bleeding without any of the above features
Category 3 (clinically recommended to be seen within 365 calendar days)	• Suspected colonic polyp with minimal rectal bleeding

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:
  - ‘Blue Book’, growth charts or any recent growth measurements
  - Full blood count (FBC)
  - Liver function test results
  - Iron studies
  - C-reactive protein (CRP)
  - Erythrocyte sedimentation rate (ESR)

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- Coagulation studies

Additional information (if available)

- Faecal multiplex PCR results
- Faecal helicobacter pylori antigen
- Faecal calprotectin result if diarrhoea > 6 weeks (in children aged ≥ 4 years)
- Previous investigations and reports (e.g. endoscopy, radiological reports)
- 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)

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Inflammatory bowel disease (suspected or known) (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 known inflammatory bowel disease with severe abdominal pain and/or bloody diarrhoea, and any of the following features:
  - Fever
  - Haemodynamic compromise
  - Suspected megacolon
  - Suspected bowel perforation
  - Bowel obstruction
  - Abscess (abdominal or perianal)
  - Haemoglobin < 90 g/L

Out of scope (not routinely provided)

- Bloody diarrhoea in the presence of bacterial infection found on stool multiplex PCR

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Suspected or known inflammatory bowel disease where chronic diarrhoea (bloody or non-bloody) or other symptoms > 4 weeks with elevated faecal calprotectin (> 250 mcg/g), and any of the following critical features are present: ○ New progressive gastrointestinal symptoms (e.g. abdominal pain, vomiting) ○ Faltering growth (weight loss of ≥ 2 weight centiles) ○ Perianal pain or fistulae suspected ○ Laboratory critical feature: - Anaemia - Low albumin - Elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP) - Iron deficiency - Holotranscobalamin (active vitamin B12) deficiency ○ Abnormal imaging suggesting inflammatory bowel disease *Note: faecal calprotectin levels can be elevated in healthy, pre-school aged children and should be interpreted with caution*
Category 2 (clinically recommended to be seen within 90 calendar days)	• Suspected inflammatory bowel disease where chronic diarrhoea (non-bloody) or other symptoms > 6 weeks with elevated faecal calprotectin (> 100 mcg/g), and none of the above critical features are present

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	• Known inflammatory bowel disease with a flare of symptoms, and none of the above critical factors are present
Category 3 (clinically recommended to be seen within 365 calendar days)	• Known inflammatory bowel disease for routine follow-up

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:
  - 'Blue Book', growth charts or any recent growth measurements
  - Stool multiplex PCR negative and *Clostridium difficile* toxin
  - Faecal calprotectin result (in children aged ≥ 4 years)
  - Full blood count (FBC)
  - Liver function test result
  - Electrolytes, urea and creatinine (EUC)
  - Iron studies
  - Holotranscobalamin (active vitamin B12)
  - C-reactive protein (CRP)
  - Relevant imaging reports
  - Current and previous colonoscopy results

Additional information (if available)

- Personal or family history of inflammatory bowel disease
- 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)

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Liver dysfunction (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 liver failure (e.g. INR > 1.5 and encephalopathy or INR ≥ 2, in the absence of pre-existing liver disease)
- Acute paracetamol toxicity
  Note: referral is indicated to paediatrician if no liver synthetic dysfunction.
- Chronic liver failure with fever or sepsis
- Jaundice with confusion
- Newborn with persistent (> 6 weeks), severe, recurrent unconjugated hyperbilirubinemia (despite phototherapy)
  Note: phone on-call gastroenterologist for advice.
- Post-transplant jaundice with fever or sepsis
- Sudden onset, obstructive jaundice

Out of scope (not routinely provided)

- Hepatitis A with no coagulopathy that is able to have follow up in the community
- Sonographic fatty liver with normal liver function tests and normal liver and spleen size, in a child who has a weight and BMI > 85th centile as per age and sex appropriate centile chart
  Note: child would benefit from dietitian or weight management referral in the first instance.

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Newborn with persistent jaundice (> 2 weeks) with a conjugated fraction > 20% (with or without pale stools and/or dark urine) Note: presence of pale stools warrants an immediate contact to on-call gastroenterologist for advice. • Acute hepatitis with worsening liver function tests • Chronic hepatitis • Unexplained hepato-splenomegaly • Unexplained cirrhosis
Category 2 (clinically recommended to be seen within 90 calendar days)	• Liver lesion on ultrasound with normal liver function tests • Liver disease treatment required that is outside the referrer's scope of practice (e.g. viral hepatitis, autoimmune liver disease, primary sclerosing cholangitis, Wilson's disease, metabolic diseases) • Suspected steatotic liver disease or metabolic associated fatty liver disease (MAFLD)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

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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:
    - Use of nutritional supplementation and/or over the counter and herbal medicines
    - Risk factors for viral hepatitis
    - Liver function test results (current and previous)
    - Full blood count (FBC)
    - Coagulation profile
    - Hepatitis A serology (HAV IgG)
    - Hepatitis B serology (HBV sAg, sAb, cAb)
    - Hepatitis C serology (HCV Ab)
    - Iron studies
    - Epstein-Barr virus (EBV) and cytomegalovirus (CMV) serology
    - Upper abdomen ultrasound

Additional information (if available)

- Alcohol intake (duration and quantity) (if relevant)
- Vaccination history
- Any relevant family history
- Current body mass index, height, weight and other relevant growth parameters
- 'Blue Book', growth charts or any recent growth measurements
- HbA1c
- Creatine kinase (in presence of elevated transaminases)
- Previous ultrasound, CT or MRI reports
- Additional pathology tests (e.g. autoimmune hepatitis, Wilson's disease, genetic disorders)
- 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)

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Nutritional and weight concerns (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 onset vomiting and/or diarrhoea in the context of dehydration unable to be managed hydration at home and/or electrolyte disturbances

Out of scope (not routinely provided)

- Anaemia or iron deficiency secondary to haematological, renal, dietary, physiological or gynaecological cause
- Intentional weight loss or body dysmorphia
- Isolated low serum ferritin without anaemia, nutritional or weight concerns
- Normochromic, normocytic anaemia with normal iron studies
- Weight loss in the neonatal period
  Note: referral should be made to paediatrician.

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• ≥ 5% unexplained weight loss in past 1 month or ≥ 10% unexplained weight loss in past 6 months with any of the following:
	  ○ Features of inflammatory bowel disease
	  ○ Features of coeliac disease
	  ○ > 4 weeks of vomiting and/or diarrhoea
	  ○ Evidence of fat malabsorption
	  ○ Low serum albumin
	  ○ Severe malnutrition (body mass index Z-score of -3) with underlying cause or contributing factors warranting specialist review
	• Severe, unexplained iron deficiency anaemia (Hb < 90)

Category 2 (clinically recommended to be seen within 90 calendar days)	• Child or infant whose current weight or rate of weight gain is significantly below that expected for age and sex, or if weight has decreased ≥ 2 major percentile lines (despite paediatric dietetic intervention for nutrition support) Note: referral should be made from paediatrician. • Recurrent, unexplained iron deficiency with or without anaemia (despite appropriate trial of oral iron therapy) Note: see Royal Children's Hospital Melbourne guidelines on oral iron replacement. • Recurrent vitamin B12 deficiency
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

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Required information

- Reason for referral
- Details of the presenting condition including duration 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:
    - Weight loss (amount and timeframe)
    - 'Blue Book', growth charts or any recent growth measurements
    - Full blood count (FBC)
    - Haematinics (iron studies, red blood cell count, folate, active vitamin B12 – holotranscobalamin), if suspicious of malabsorption, child has a restricted dietary intake, vegan or vegetarian diet
    - Coeliac serology: tissue transglutaminase IgA (TTG IgA), total IgA (where possible) with or without anti-endomysial antibody (EMA), if infant is on solids or feeds contain gluten
    - Faecal multiplex PCR
    - Stool MCS, ova cysts parasites (OCP)

Additional information (if available)

- Paediatrician report
- Urinalysis, microscopy and culture (especially infants < 12 months of age, as occult urinary tract infection can present with slow weight gain)
- Electrolytes, urea and creatinine (EUC)
- Thyroid stimulating hormone (TSH)
- Liver function test results
- Random glucose
- Presence of fat globules and/or fatty acid crystals on stool microscopy
- Faecal elastase
- C-reactive protein (CRP)
- Erythrocyte sedimentation rate (ESR)
- Faecal calprotectin result (in children aged ≥ 4 years)
- 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)

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Upper gastrointestinal dysfunction (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.

- Caustic ingestion
- Dysphagia with obstruction from food
- Suspected or known oesophageal foreign body (especially button battery or > 1 magnet)

Note: local or network guidelines may determine the appropriate specialty or service to manage these presentations.

Out of scope (not routinely provided)

- < 4 weeks of vomiting
- Infantile reflux or colic

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Recurrent dysphagia with previous food bolus obstruction and/or decrease of ≥ 2 weight centiles • Persistent or recurrent vomiting with small volume haematemesis
Category 2 (clinically recommended to be seen within 90 calendar days)	• Aged > 2 years with reflux and recurrent or persistent dyspepsia despite 2-month trial of proton pump inhibitors • Failure to progress to solid foods (after speech pathology and/or dietetics review) • Lack of progression to harder food textures due to swallowing difficulties (after speech pathology and/or dietetics review) • Dysphagia without faltering growth and/or weight loss • Persistent or recurrent vomiting (≥ 4 weeks) without small volume haematemesis • Positive *Helicobacter pylori* testing (stool antigen or urea breath test) in the presence of refractory upper gastrointestinal symptoms and associated with iron deficiency anaemia and/or family history of gastrointestinal cancer Note: *Helicobacter pylori* testing not indicated in the absence of above features.
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nausea with associated weight loss ≥ 2 weight centiles with or without vomiting • Aged > 2 years with painless, effortless regurgitation

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Required information

- Reason for referral
- Details of the presenting condition including duration 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:
    - Weight loss (amount and timeframe)
    - 'Blue Book', growth charts or any recent growth measurements
    - Medical management to date (e.g. proton pump inhibitors, *Helicobacter pylori* treatment)

Additional information (if available)

- Previous endoscopy or histopathology results
- Recent pathology reports
- *Helicobacter pylori* results, including urea breath tests
- Relevant imaging reports
- 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)

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