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## SERVICE DESCRIPTION

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</table>
1.0 REFERRAL TYPE AND ACTION

1.1 Urgent or acute referrals are those that need to be seen immediately for assessment and treatment at the Emergency Department or via acute clinics e.g. General Medicine Acute Assessment Clinic, Gynaecology Unit, Antenatal Unit, Elderly General Geriatric, Psycho-geriatric, Children’s Assessment Unit.

- These referrals may be made by phone to the discipline registrar on duty or on call.
- Where a referral is made by phone it is preferable that a written referral follows.
- A written referral should be given to the patient to bring to the Emergency Department.
- Electronic referrals will be possible in the future.

1.2 Non Acute or Arranged Referrals are those that need assessment by a specialist service to ascertain need for elective surgery or other outpatient clinic appointments, treatment or onward referral. (Refer to flowchart on page 10.) The current Assessment Criteria for First Specialist Assessment (ACA) can be found with some service descriptions. As national clinical guidelines are finalised, these will supersede those in the manual.

- These are written referrals that must meet the minimum essential referral information as in 2.0 on page 5.

1.3 Diagnostic referrals are those that require a diagnostic test/intervention to confirm or exclude provisional diagnoses.

1.4 Specialized Nursing and Allied Health referrals are those that require assessment and/or treatment that is unable to be reasonably provided by the GP or practice nurse. Services are provided in an outpatient or community setting.

- These are phoned or written referrals that must meet the minimum essential referral information as in 2.0 on page 5.

A flowchart is included on page 11 to assist with clarification of processes.
2.0 Referral Information

All referrers must provide the following information on all referrals:
This can be done by using the MidCentral Health referral form (see sample forms pages 6 and 7) obtainable free, by phoning the MidCentral Health Distribution Centre, by using your own letterhead or sending them electronically when this facility is available. A referral that does not meet the minimum essential requirements will not be accepted. These requirements match those of the National Generic Referral Letter.

- Name in full (Family and all First Names)
- National Health Index (NHI) number
- Residential and postal address
- Home and alternative phone numbers
- Date of birth
- Presenting clinical history and relevant past clinical history
- Physical and psychological findings
- Response to treatment
- Medications
- Allergies and alerts
- Social situation
- Investigations (include date and result)
- Medical practitioner’s demographics, date, signature, phone and fax
- Specific referral information for the speciality – refer A–Z section.

Include if known or relevant:

- Past and present occupation and present employer
- Ethnicity
- Residency status
- Contact person/advocate name, address and phone number
- Previous attendance at a public hospital.

All accident related referrals must contain the following information:

- Date of injury
- A copy of the ACC 45 including signature and diagnosis
- Work or non work related injury
- Read code, site and type of injury
- Prior approval by the ACC Case Manager if the injury >7 days
- Past and present occupation and present employer.

Where a referral is being made to a service and the reason for referral is as a result of an accident the patient can be referred to a Specialist in their private capacity.
3.0 REFERRAL DESTINATION

Urgent or Acute Referrals:
- Referrals for patients requiring acute assessment may be faxed or sent with the patient to the Emergency Department or via acute clinics e.g. General Medicine Acute Assessment Clinic, Gynaecology Unit, Antenatal Unit, Elderly General Geriatric, Psycho-geriatric, and Children’s Assessment Unit.

Non Acute or Arranged Referrals:
- Must be addressed to the specialty or service rather than the individual specialist and forwarded to the Ambulatory Care Centre using the teal envelope available free by phoning the MidCentral Health Distribution Centre.

  • “XYZ” Service  
    c/- Ambulatory Care Centre  
    Palmerston North Hospital  
    Private Bag 11036  
    Palmerston North  
    Email: ambulatorycare@midcentral.co.nz

Specialized Nursing and Allied Health:
- Primarily Allied Health, Therapy and Specialized Nursing Services  
  - Central Referral Management  
    Rehabilitation Service  
    Palmerston North Hospital  
    Private Bag 11036  
    Palmerston North  
    Phone: (06) 350 8182 or 0800 741 222  
    Fax: (06) 350 8122  
    Email: CentralReferral@midcentral.co.nz

- All other services including diagnostics not in the above groups. Each service description includes a destination for referral.

- Where referrals are sent to an incorrect destination they will be forwarded promptly.
4.0 TIMEFRAME FOR RESPONSE

GPs will receive the following information electronically via the Regional Clinical Information Network (RCIN) on a daily basis:

- Within 10 working days – date of receipt, specialist name and priority
- Appointment date when scheduled
- “Did not attends” and cancellations

NB: Where diagnostic tests are required before the first specialist appointment the specialist will arrange these at the time of prioritising the referral.

The following process will also occur:

- Within five working days – referrals that do not meet the minimum essential information requirements will be returned to the referral source.

Patients will receive the following information by letter:

- Within 10 working days – date of receipt, specialist name and optional information that may include appointment details, pre tests required and preadmission information.

Patients categorised into Active Care and Review (ACR) will receive their plan of care.

5.0 NATIONAL REFERRAL GUIDELINES

Groups of specialists and GPs have been working together to develop guidelines that can support nationally consistent referrals.

Included in the information for each service, are either the MCH criteria for prioritisation or, if published, the service’s National Referral Guideline:

1) The access criteria for first specialist assessment (ACA) which is the priority and timeframe for assessment given by a specialist to a referral based on clinical criteria.

2) The clinical priority assessment criteria (CPAC) which is a tool for calculating priority for treatment.

For further supporting advice and information to be provided to the specialist service receiving the referral, refer to the Ministry of Health website:
http://www.nzgg.org.nz/moh-esg/

MidCentral Health is required to audit referrals against the National Guidelines. Referrals will be returned to the referrer or referred back by phone for further information if incomplete.
PROCESS FOLLOWING REFERRAL FOR ELECTIVE SURGERY

GP Referral
Referral or letter sent to Specialist Clinic

Referral Prioritised
- Urgent
- Semi urgent
- Routine

Outpatient Appointment Booking
Date of clinic booking

Outpatient Clinic Attendance
CPAC Score

Treatment Decision and Prioritisation
- Booked date for surgery
- Certainty of date within six months
- ACRGP (Active Care and Review completed by GP) are referred back to GP & reassessed in 6 months by the GP
- ACR (Active Care and Review completed by Specialist) are referred back to the GP and reassessed within 6 months by the Specialist

Date for surgery given

Pre-admission Process
- Patient is screened & processed

Stream 1
Healthy Day Case
(Do not need to physically attend pre-admit clinic)
- Paperwork is screened

Stream 2
General Assessment
Pre-admit clinic appointment for:
- Nurse assessment
- Surgical Team assessment

Stream 3
Anaesthetist Assessment
Pre-admit clinic appointment for:
- Anaesthetist assessment
- Nurse assessment
- Surgical Team assessment

Day of Surgery Admission Unit (DOSA)
Patient goes to DOSA (in theatre) to be prepped for surgery

Theatre

Recovery

(Day Case)
Possible transfer to Transit Lounge

To Ward

(Inpatient)

Discharged

Discharged

- notification of GP
FOCUS AND SCOPE:
Consultation and advice on alcohol, benzodiazepines, opiate and polydrug dependency, including cannabis.
The Alcohol and Drug Service can provide:
- Assessment Services
- Referral for dual diagnosis
- Alcohol and Drug counselling services
- Outpatient treatment
- Home detoxification services
- Hospital inpatient detoxification services
- Referral to residential alcohol and drug rehabilitation services
- Methadone treatment
- Section 30A assessments.

SPECIFIC REFERRAL INFORMATION:
Nil.

TESTS REQUIRED:
Suggested investigations:
- Blood screens
- Liver enzyme levels
- Serology for hepatitis B, hepatitis C, infectious mono
- HIV where appropriate
- A urine drug screen.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 9130  Postal: Nikau House
Fax: (06) 350 8832  Community Health Village
Email: ALDRUGQ@midcentral.co.nz  Palmerston North Hospital
Postal: Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:
8.30 am – 5.00 pm, Monday to Friday.
**FOCUS AND SCOPE:**
Provides audiological assessments for all age groups and provision of hearing aids when required. Close links to Neonatal Unit and Paediatric Clinic.

**SPECIFIC REFERRAL INFORMATION:**
Need to make sure ears are clear/checked visually prior to referral
Useful to have parent and/or teachers’ comments (e.g. attention span)
If noise induced hearing loss suspected and patient aiming to claim ACC, referral needs to be to an ORL Specialist (refer to “ENT/ORL” section in this folder).
Industrial hearing loss – ACC Form and referral to private practice.

**TESTS REQUIRED (PRIOR TO REFERRAL):**
None. Some General Practitioners perform a simple audiogram prior to referral.

**OTHER INFORMATION:**
Nil.

**CONTACT:**
Phone: (06) 350 8610
Answer phone available.
E-mail: ambulatorycare@midcentral.co.nz
Postal: Ambulatory Care Centre
Palmerston North Hospital
Private Bag 11036
Palmerston North

**HOURS OF ATTENDANCE:**
8.00 am – 5.00 pm.
BREASTSCREEN COAST TO COAST

FOCUS AND SCOPE:
BreastScreen Coast to Coast is one of eight lead providers for BreastScreen Aotearoa, the Ministry of Health National Breast Screening Programme, for women aged 45-69.

SPECIFIC REFERRAL INFORMATION:
Women are encouraged to self enrol by phoning 0800 270 200. Fax forms are available for Health Professionals enrolling women.

TESTS REQUIRED:
Nil. This is a well-woman programme for screening mammograms only. Women with symptoms should be seen by their GP for referral for a diagnostic mammogram.

OTHER INFORMATION:
With the woman’s permission, her GP will receive a copy of the results. GPs are welcome to visit the centre.

CONTACT:
Phone: 0800 270 200 Postal: BreastScreen
Fax: (06) 350 1531 Coast to Coast
Email: breastscreen@midcentral.co.nz Private Bag 11036
Postal: Coast to Coast
Private Bag 11036 Palmerston North

HOURS OF ATTENDANCE:
9.00 am – 4.00 pm, Monday to Friday.
Base site: 27 Amesbury Street
Mobile sites at Dannevirke, Feilding, Foxton, Levin and Pahiatua. (Two yearly visits.)
FOCUS AND SCOPE:
Assessment, investigation and education for patients with cardiac disease.

SPECIFIC REFERRAL INFORMATION:
Referrals can be made for cardiac rehabilitation and heart failure nurse management services.
Detailed history, including family history of high cholesterol and premature heart disease.
Evidence of Coronary Artery Disease.
Smoking status.
Relevant blood results.
Copies of relevant correspondence from other hospitals.

TESTS REQUIRED:
Lipid profiles and lipid levels for patients with hyperlipidemia.

OTHER INFORMATION:
List of patient treatment.

CONTACT:
Phone: (06) 350 8282
Fax: (06) 350-8285
Nurse Specialist: (06) 350-8281
Nurse Clinicians: (06) 350-8617
E-mail: ambulatorycare@midcentral.co.nz
Indications for Holter Monitoring

Urgent
1. Recurrent presyncope, syncope not explained by examination findings or other investigations. Consider urgent referral +/- admission.

Semi-Urgent
1. Daily/frequent symptomatic palpitations associated with dyspnoea, presyncope or chest pain, not otherwise documented.
2. Daily/frequent palpitations which are interfering with subjects confidence or ability to continue usual activities, not otherwise documented.

Note: frequent = 2-3 per week.

Indications for Electrophysiology Studies (±Ablation*)

For GP information: note urgent, semi-urgent and non urgent categories

Urgent
1. Resuscitated cardiac arrest, due to ventricular fibrillation or tachycardia, not due to acute myocardial infarction or an identified and corrected cause.
2. Recurrent ventricular tachycardia that is not controlled with medical therapy (ablation may be applicable).
3. Sustained broad complex tachycardia, where the diagnosis is not clear or tachycardia not controlled with medical therapy, or structural heart disease is absent (ablation may be applicable).
4. Non sustained ventricular tachycardia following myocardial infarction, left ventricular ejection fraction <35%.
5. Recurrent syncope, otherwise unexplained in a patient with structural cardiac disease.

GP Referral for:

Semi-Urgent
   * Recurrent supraventricular tachycardia either not controlled with medical therapy, or the patient prefers ablation over medical therapy
2. *Recurrent atrial flutter when ablation is being considered.
3. *Recurrent atrial fibrillation, when ablation is being considered.
4. *Atrial fibrillation (paroxysmal or chronic) without control of symptoms or rate with medical therapy, for AV nodel ablation and pacing.

Non Urgent
1. Asymptomatic Wolff-Parkinson-White Syndrome

* These are indications for EPS studies and ablation.
National Access Criteria for First Assessment (ACA)

**Category Definitions**: These are recommended guidelines for HHS specialists prioritizing referrals from cardiology.

1. **Immediately**
   - Immediately in hospital
2. **Urgent**
   - Within 1 week
3. **Semi-Urgent**
   - Within 2 weeks
4. **Routine**
   - Within 6 weeks

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

### NATIONAL REFERRAL GUIDELINES: CARDIOLOGY / CARDIAC SURGERY

<table>
<thead>
<tr>
<th>Category</th>
<th>Symptomatology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>Pain on rest or pain on mobilising (class IV, A, B &amp; C).</td>
</tr>
<tr>
<td></td>
<td>ETT marked positive (+++).</td>
</tr>
<tr>
<td></td>
<td>Spontaneous pain in hospital.</td>
</tr>
<tr>
<td></td>
<td>Post MI</td>
</tr>
<tr>
<td></td>
<td>• thrombolyss x? in hospital (same admission)</td>
</tr>
<tr>
<td></td>
<td>• cardiogenic shock</td>
</tr>
<tr>
<td></td>
<td>• complications (eg. VSD, severe MR, subacute rupture)</td>
</tr>
<tr>
<td></td>
<td>• positive troponin T at presentation</td>
</tr>
<tr>
<td></td>
<td>• decrease in ventricular function</td>
</tr>
<tr>
<td></td>
<td>Patients needing hospital surgery + requiring diagnostic coronary arteriogram.</td>
</tr>
<tr>
<td></td>
<td>Some patients requiring transplant assessment / VT or VF investigation.</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>Class III/IV-A on resorable treatment (at least B Blocker, vasodilator).</td>
</tr>
<tr>
<td></td>
<td>ETT - very positive (+), but not satisfying markedly positive criteria.</td>
</tr>
<tr>
<td></td>
<td>Diagnosis for severe associated valvular heart disease.</td>
</tr>
<tr>
<td>3. Semi Urgent</td>
<td>Continuing angina (Class II-III) despite reasonable treatment (see above).</td>
</tr>
<tr>
<td></td>
<td>And/or positive (+) ETT</td>
</tr>
<tr>
<td>4. Routine</td>
<td>Remainder</td>
</tr>
</tbody>
</table>
National Access Criteria for First Assessment (ACA)

Category Definitions: These are recommended guidelines for HHS specialists prioritizing referrals from cardiologists.
1. Immediately - immediately in hospital
2. Urgent - within 1 week
3. Semi-urgent - within 2 weeks
4. Routine - within 6 weeks

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Symptomatology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>Pain on rest or pain on mobilising (class IV, A, B &amp; C). ETT marked positive (+ +). Spontaneous pain in hospital. Post MI&lt;br&gt;• thrombolytic x2 in hospital (same admission)&lt;br&gt;• cardiogenic shock&lt;br&gt;• complications (e.g., VSD, severe MR, subacute rupture)&lt;br&gt;• positive troponin T at presentation&lt;br&gt;• decrease in ventricular function&lt;br&gt;Patients needing hospital surgery + requiring diagnostic coronary arteriogram. Some patients requiring transplant assessment / VT or VF investigation.</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>Class III / IV A on reasonable treatment (at least B Blocker, vasodilator). ETT - very positive (+ +), but not satisfying markedly positive criteria. Diagnosis of severe associated valvular heart disease.</td>
</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>Continuing angina (Class II-III) despite reasonable treatment (see above). And/or positive (+) ETT</td>
</tr>
<tr>
<td>4. Routine</td>
<td>Remainder</td>
</tr>
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# Definition of Terms

## ANGINA SEVERITY

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<th>Class</th>
<th>Description of Class (Canadian Cardiovascular Society angina classification)</th>
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<td>Class I</td>
<td>Stable angina - CCS I.</td>
</tr>
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<td>Class II</td>
<td>Stable angina - CCS II.</td>
</tr>
<tr>
<td>Class III</td>
<td>Stable angina - CCS III.</td>
</tr>
<tr>
<td>Class IV-A</td>
<td>Stable angina - CCS IV or unstable angina, pain resolved with intensified medical therapy, and now stable on oral medication.</td>
</tr>
<tr>
<td>Class IV-B</td>
<td>Unstable angina, on oral therapy, symptoms improved but angina with minimal provocation.</td>
</tr>
<tr>
<td>Class IV-C</td>
<td>Unstable angina, not manageable on oral therapy, requires parenteral medication, may be haemodynamically unstable.</td>
</tr>
</tbody>
</table>

### Stable angina: Canadian Cardiovascular Society (CCS) classification system

- **Class I**: Ordinary physical activity does not cause angina, such as walking, climbing stairs. Angina [occurs] with strenuous, rapid, or prolonged exertion at work or recreation.
- **Class II**: Slight limitation of ordinary activity. Angina occurs on walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, or in cold, or in wind, or under emotional stress, or only during the few hours after awakening. Walking more than two blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.
- **Class III**: Marked limitations of ordinary physical activity. Angina occurs on walking one to two blocks on the level and climbing one flight of stairs in normal conditions and at a normal pace.
- **Class IV**: Inability to carry on any physical activity without discomfort - anginal symptoms may be present at rest.

### Exercise Test: Treadmill, Bruce protocol

- **Negative or <2mm ST depression**: Stage IV
- **Mildly positive**:
  - >2mm ST depression
  - or pain and <2mm ST depression
  - Stage IV
- **Positive**
  - >2mm ST depression
  - or pain and <2mm ST depression
  - Stage III
- **Very positive**
  - >2mm ST depression
  - or pain and <2mm ST depression
  - Stage II
- **Markedly positive**
  - >2mm ST depression
  - or BP fall >15mm Hg
  - Stage I or II
- **or unsafe to perform test**

### Notes:
- "Pain" also includes 'anginal equivalent' symptoms.
- Test performed after patient stabilised (if initially unsafe).
- 2mm ST depression is in addition to any resting ST depression.
- If unable to exercise, a positive pharmacological test (reversible perfusion defect on thallium, reversible regional wall motion abnormality on stress echocardiography) is regarded as "very positive".

### Unstable angina: NHLBI classification, modified from Braunwald

- **Rest angina**: Angina occurring at rest and usually prolonged >20 minutes occurring within a week of presentation.
- **New onset angina**: Angina of at least CCS III severity with onset within 2 months of initial presentation.
- **Increasing angina**: Previously diagnosed angina that is distinctly more frequent, longer in duration or lower in threshold (i.e. increased by at least one CCS class within 2 months of initial presentation to at least CCS III severity).
# CARDIOLOGY

National Access Criteria for First Assessment (ACA)

## REFERRAL FOR PACEMAKER IMPLANTATION

**Category Definitions**: These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. Immediate - Pacemaker required immediately (ASAP)
2. Urgent - Pacemaker required within 48 hours
3. Semi-urgent - Pacemaker required within 2 weeks
4. Routine - Pacemaker required within 8 weeks

It is axiomatic that these criteria will not replace clinical judgement in the treatment of individual patients.

### NATIONAL REFERRAL GUIDELINES: CARDIOLOGY

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis (examples)</th>
<th>Conditions (not exhaustive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>Acquired complete AV block Lead/generator failure Prolonged asystole</td>
<td>Immediate threat to patient’s life</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>Acquired complete AV block Bifascicular or Trifascicular block Long QT syndrome</td>
<td>Congestive heart failure Confusion Temporary wire in situ (no longer than 24hrs) Failing epicardial wires (post surgical) Post MI – may be asymptomatic</td>
</tr>
<tr>
<td>3. Semi Urgent</td>
<td>Acquired complete AV block Congenital complete AV block Second degree (Mobitz II) block Sino-atrial disease</td>
<td>Syncope Asymptomatic Any symptoms attributable to bradycardia Any symptoms attributable to bradycardia Bradycardia-related syncope, dizziness or confusion</td>
</tr>
<tr>
<td>4. Routine</td>
<td>Malignant Vasovagal syndrome Carotid sinus syndrome Generator replacement at End Of Life Upgrade of pacing mode</td>
<td>Symptomatic bradycardia secondary to tachycardia Recurrent vasovagal syncope Torsade de pointes related to bradycardia</td>
</tr>
<tr>
<td>Category</td>
<td>Diagnosis</td>
<td>Referral Guidelines</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 3. Semi-Urgent | • Stable patients with known or suspected cardiac conditions where rapid deterioration is unlikely | • Stable angina  
• Chest pain for diagnosis  
• Shortness of breath? Cardiac basis  
• Chronic atrial fibrillation  
• Palpitations  
• Severe hypertension refractory to treatment  
• A person whose employment status is threatened |
| 4. Routine    | • Mild or moderate functional impairment                                    | • Asymptomatic murmur  
• Asymptomatic cardiomegaly  
• Difficult to control hypertension  
• Secondary hypertension  
• Hypertension with cardiomegaly  
• Asymptomatic patients with ECG changes |
|              | • Reassessment of stable patients requiring review of current treatment where appropriate | • Asymptomatic vascular disease  
• Hyperlipidaemia  
• Transfers of patients into care |
|              | • Not normally seen                                                          | • Mild hypertension  
• Life insurance assessments |

Notes:
- Patients are prioritised by individual clinician judgement
- Preoperative assessments will be determined by the urgency of the non-cardiac surgery
- Exclusions: not seen mild hypertension, insurance assessments, work assessments
# Cardiology

## National Clinical Priority Assessment Criteria (CPAC)

### Cardiac Catheterisation

- **Patient ID:** Complete patient details or place patient sticker here
- **National Hospital No.:**
- **Consultant:**
- **Name:**
- **D.O.B.** __/__/___
- **Address:**

| Name of Assessor: |
| Date of Assessment: __/__/___ |

### 1. Angina on Beta Blocker and/or C Antagonist

<table>
<thead>
<tr>
<th>Class</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>0</td>
</tr>
<tr>
<td>Class I</td>
<td>2</td>
</tr>
<tr>
<td>Class II</td>
<td>10</td>
</tr>
<tr>
<td>Class III</td>
<td>20</td>
</tr>
<tr>
<td>Class IV-A</td>
<td>25</td>
</tr>
<tr>
<td>Class IV-B</td>
<td>30</td>
</tr>
<tr>
<td>Class IV-C</td>
<td>35</td>
</tr>
</tbody>
</table>

*Maximum 35*

### 2. ETT on Beta Blocker and/or C Antagonist

<table>
<thead>
<tr>
<th>Class</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markedly Positive</td>
<td>20</td>
</tr>
<tr>
<td>Very Positive</td>
<td>16</td>
</tr>
<tr>
<td>Positive</td>
<td>8</td>
</tr>
<tr>
<td>Mildly Positive</td>
<td>4</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
</tr>
</tbody>
</table>

*Maximum 20*

### 3. Other Diagnoses (Max 30 Points)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Valvular HD</td>
<td>+15</td>
</tr>
<tr>
<td>Severe Valvular HD</td>
<td>+30</td>
</tr>
<tr>
<td>Severe LV Impairment</td>
<td>+20</td>
</tr>
<tr>
<td>Moderate LV Impairment</td>
<td>+10</td>
</tr>
<tr>
<td>Early Instability Post MI</td>
<td>+15</td>
</tr>
<tr>
<td>Recent Unstable Angina with ST/T Wave Changes</td>
<td>+15</td>
</tr>
</tbody>
</table>

*Maximum 30*

### 4. Ability to Work, Give Care to Dependent(s) or Live Independently

<table>
<thead>
<tr>
<th>Status</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately threatened</td>
<td>15</td>
</tr>
<tr>
<td>Threatened but not immediate</td>
<td>5</td>
</tr>
<tr>
<td>Not threatened but more difficult</td>
<td>1</td>
</tr>
</tbody>
</table>

*Maximum 15*

### Urgent Catheter If:

- Class IV angina
- Markedly positive ETT
- Class III and very positive ETT
- Severe valvular HD

### Semi Urgent If:

- Class III Angina
- Very positive
- Class III and positive
- Class II and very positive
# CARDIOLOGY

## National Clinical Priority Assessment Criteria (CPAC)

### PERCUTANEOUS CORONARY REvascularisation

**Degree of coronary artery obstruction**

<table>
<thead>
<tr>
<th>Obstruction</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No CAD &gt; 50%</td>
<td>0</td>
</tr>
<tr>
<td>1 VD 50-74%</td>
<td>6</td>
</tr>
<tr>
<td>&gt; 1 VD 50-74%</td>
<td>7</td>
</tr>
<tr>
<td>1 VD &gt; 75%</td>
<td>7</td>
</tr>
<tr>
<td>1 VD &gt; 90%</td>
<td>10</td>
</tr>
<tr>
<td>2 VD 50-89%</td>
<td>12</td>
</tr>
<tr>
<td>2 VD both &gt; 90%</td>
<td>15</td>
</tr>
<tr>
<td>1 VD &gt; 50% proximal LAD</td>
<td>20</td>
</tr>
<tr>
<td>3 VD or 2 VD incl. proximal LAD</td>
<td>20</td>
</tr>
</tbody>
</table>

**Angina**

<table>
<thead>
<tr>
<th>Class</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>2</td>
</tr>
<tr>
<td>II</td>
<td>10</td>
</tr>
<tr>
<td>III</td>
<td>20</td>
</tr>
<tr>
<td>IV-A</td>
<td>25</td>
</tr>
<tr>
<td>IV-B</td>
<td>30</td>
</tr>
<tr>
<td>IV-C</td>
<td>35</td>
</tr>
</tbody>
</table>

**Exercise stress test**

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markedly positive</td>
<td>20</td>
</tr>
<tr>
<td>Very positive</td>
<td>16</td>
</tr>
<tr>
<td>Positive</td>
<td>8</td>
</tr>
<tr>
<td>Mildly positive</td>
<td>4</td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
</tr>
</tbody>
</table>

**Other angiographic features**

- Recent < 3 mo occlusion: 10
- Critical vein graft stenosis: 10
- Slow flow (TIMI 2): 10
- Complex lesion (ulcerated, type C, irregular): 10

**Note:** Maximum 10 points from this criterion

**Ability to work, give care, live independently**

<table>
<thead>
<tr>
<th>Status</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately threatened</td>
<td>15</td>
</tr>
<tr>
<td>Threatened but not immediate</td>
<td>5</td>
</tr>
<tr>
<td>Not threatened but more difficult</td>
<td>1</td>
</tr>
</tbody>
</table>

**Maximum 15**

---

**Total Score =**
SPECIALIST REFERRAL FORM

Mr | Mrs | Ms
Name: Family Name

Sex: Date of Birth:

Patient Hospital Number:

Given Names:

Home Phone:

Work/Daytime Phone:

Residential Address:

Occupation:

Ethnicity:

Postal Address:

Employer:

NZ Resident: ☐ Yes ☐ No
If no, where:

Previous attendance at a public hospital:

☐ Yes ☐ No If Yes: Date?

Insurer Name:

Claim Number:

Date of Injury:

Reason for Referral: ( Provisional diagnosis)

Investigation, Results, Date & Location (Include Blood, Radiology & ECG)

Medical Practitioner name/address/phone number and fax (Please print or stamp)

Date:

Signature:

Date Received:

Appointment Date:

Appointment Time:

Prioritisation Category:

Sign:

Date:

Tests Required:
FOCUS AND SCOPE:
Provision of mental health care to people aged 0–18 years who have or whose family member has a significant mental health disorder. There should be no unresolved care and protection issues or court proceedings (e.g. custody/access).

SPECIFIC REFERRAL INFORMATION:
For referral of a young person (less than 18 years) a Child Adolescent and Family Services referral form is available or your letter should include the following:
- Name of parent, step parent, legal guardian or caregiver
- Other family members with relevant phone numbers
- Reason for referral
- Presenting problem (be specific)
- How is the presenting problem disrupting family life?
- History of current problem
- Other relevant details
- Are there any significant health problems within the family?
- Recent medical investigations and outcome
- Paediatrician
- Current medications
- Other services involved (CYFS, Special Education Service, ACC, police, registered private counsellor, and respite care agencies).

Non urgent referrals should be made by letter to the Children’s Clinic at Palmerston North Hospital, phone: (06) 350-8660, fax: (06) 350-8662.

TESTS REQUIRED:
Nil. If any investigations have been arranged, copies of original full results must accompany referral.

OTHER INFORMATION:
If client identifies as Maori, refer to Oranga Hinengaro (Specialist Maori Mental Health Team). Refer to Mental Health Services in this folder.

CONTACT:
Phone: (06) 350 8373  Postal: Konini House
Fax: (06) 350 8374  Ruahine Street
                           MidCentral Health
                           P O Box 2056
                           Palmerston North

All referral letters should be sent to the Children’s Clinic, Palmerston North Hospital.
FOCUS AND SCOPE:
The Child Health Service provides assessment, investigation and treatment of all health related problems for children referred. Generally the service is provided for children up to the age of 14 years.

SPECIFIC REFERRAL INFORMATION:
Acute admissions can be facilitated following a phone call to the Paediatric Registrar on duty. Children will generally be assessed in the Children’s Assessment Unit. Not all of these children will necessarily be admitted and it is important that parents are aware that following assessment, some children may be sent home.
Urgent or semi urgent referrals (for a child who has a condition that requires assessment or advice within one week) a phone call should be made to the Consultant Paediatrician on call and not the Registrar.
Non urgent referrals should be made by letter to the Children’s Clinic Receptionist at Palmerston North Hospital, phone (06) 350 8660, and fax (06) 350 8662.
Referral letters must include details of problem, past history, family history and caregivers, and any previous specialist involvement. If incomplete, letters will be returned to referrer.

TESTS REQUIRED:
No routine tests are required. If any investigations have been arranged, copies of original full results should accompany referral.

OTHER INFORMATION:
Each Paediatrician has sub speciality interests but only some of these involve separate clinic times.

Clinics are held at Dannevirke, Pahiatua and Horowhenua in addition to Palmerston North Hospital.

All referral letters will be sent to the Children’s Clinic, Palmerston North Hospital.
# ASSESSMENT CRITERIA FOR FIRST SPECIALIST ASSESSMENT (ACA)

<table>
<thead>
<tr>
<th>Service Category: Paediatric Medicine</th>
<th>Patient Type: Outpatient (Assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category Definitions:</strong></td>
<td></td>
</tr>
<tr>
<td>1) Urgent</td>
<td>- immediately or within 2 days</td>
</tr>
<tr>
<td>2) Semi Urgent</td>
<td>- seen within 10 days</td>
</tr>
<tr>
<td>3) Routine</td>
<td>- seen within 8 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples <em>(Not an exhaustive list)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Urgent seen immediately or within 2 days</td>
<td>- Children likely to need admission on the same day</td>
<td></td>
</tr>
<tr>
<td>2) Semi-Urgent Seen within 10 days</td>
<td>- Children with urgent problem, probably not needing admission</td>
<td></td>
</tr>
<tr>
<td>3) Routine Seen within 8 weeks</td>
<td>- Children needing outpatient semi-urgent or non-urgent assessment</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
Approximately 95% of admissions occur on the day of referral. 5% are arranged by the Paediatrician for a specific investigation or treatment e.g. Oncology. The priority is to avoid admission, therefore an urgent OP assessment is provided for any patient whose GP phone the Paediatrician on call. **Telephone calls from GPs to the Paediatrician on call are encouraged.**
CHILD HEALTH REFERRAL ASSESSMENT PROCESS

Children presenting for urgent assessment/obvious admission

If under 15:
• Surgical
• Orthopaedic
• ENT
• Ophthalmology
• Urology

If under 15:
• Burns
• Cellulitis
• All other conditions requiring admission

If under 5:
• Abdominal pain
• Head injury
• Vomiting
• Neurological

Phone MidCentral Health Switchboard on (06) 356 9169 and ask to speak to:

On call registrar of speciality

Emergency Department

On call paediatric registrar

Child requested to present at:
• Emergency Department; or
• Ward; or
• Children’s Assessment Clinic

On call paediatric consultant

Advice given or decision made to assess child on site

Non-urgent referrals, outpatient assessments

Forward referral in sealed envelope to Ambulatory Care Referral Centre

Referrals sorted and forwarded to Child Health Clinic Receptionist for entering onto PIMS and forwarding to the consultant for prioritisation
FOCUS AND SCOPE:
Assessment, advice and treatment of all blood and bone marrow disorders, including leukaemia, anaemia and other cytopenias, paraproteins, bleeding disorders, thrombotic disorders and disorders of iron metabolism, including iron overload.

SPECIFIC REFERRAL INFORMATION:
Patients will be assessed by one of the Haematologists or by a Haematology Registrar under the supervision of a Haematologist. Urgent cases will be seen within 24 hours, while non-urgent cases will generally be seen within three months of a referral being received.

TESTS REQUIRED:
Copies of recent/relevant blood test results should be included with the referral.

OTHER INFORMATION:
Urgent inquiries can be directed to the Haematologist on call 24 hours a day. Non-urgent inquiries may be directed to the Clinical Haematology Department.

CONTACT:
Phone: (06) 350 8550  Postal: Clinical Haematology Service
Fax:  (06) 350 8551  Palmerston North Hospital
        Private Bag 11036
        Palmerston North
CONGESTIVE HEART FAILURE CLINIC

FOCUS AND SCOPE:

- Patients with significant heart failure (Grade II-IV) as a primary diagnosis or as an active problem, which includes at least one admission over the last year for heart failure.  
  
  OR

- Patients MUST have objective evidence of left ventricular dysfunction with cardiomegaly and pulmonary congestion on chest X-ray, or Echo evidence of EF < 45%, and/or clinical heart failure (more than gravitational oedema).  
  
  OR

- Patients whose heart failure management is complicated by:
  1. Renal impairment
  2. Drug intolerance
  3. Poor response to therapy

<table>
<thead>
<tr>
<th>New York Heart Association Functional Classes of CHF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class I</strong></td>
</tr>
<tr>
<td><strong>Class II</strong></td>
</tr>
<tr>
<td><strong>Class III</strong></td>
</tr>
<tr>
<td><strong>Class IV</strong></td>
</tr>
</tbody>
</table>

Authorised by: Dr Raffat Shameem, Cardiologist  
Prepared by: Claire O’Sullivan, CNS Cardiology

Referrals:

- For urgent referral or consultation re referrals: please contact Claire O’Sullivan CNS or Birgitte Hunt, Nurse Clinician.  
  
- **Medical Staff:** USE YELLOW REFERRAL FORM – Patients will come to Assessment Clinic and have cardiologist’s review, plus education and follow-up.  
  
- **Ward Nursing Referrals:** USE GENERIC NURSING FORM – For assessment and education PLEASE refer on admission so patient can be seen as an in-patient.

Nursing referrals to Heart Failure Assessment Clinic MUST have medical team consent.
CONTINENCE SERVICE

FOCUS AND SCOPE:
Assessment, education and advice re ongoing management of people referred with acute medical or surgical incontinence problems. Also provides longer term services for people referred with current or potentially chronic continence problems which have been unresponsive to treatment.

CRITERIA FOR SUPPLIES:
- Adult assessed as meeting the criteria of 100 mls loss four or more times per day.
- Child aged between 4 and 10 years who has an incontinence problem which is inconsistent with normal development, must be greater than 50 mls per episode and greater than four times a day, and/or a problem with bowel control.

SPECIFIC REFERRAL INFORMATION:
A physical examination of the patient, including a vaginal or rectal examination where relevant.
A medical history including any prior investigations and/or surgical interventions.
The duration of the problem.

TESTS REQUIRED:
Midstream urine where relevant.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8182
Fax: (06) 350 8122
Email: CentralReferral@midcentral.co.nz
Postal: Central Referral Management
Rehabilitation Service
Palmerston North Hospital
Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 5.00 pm, Monday to Friday.
FOCUS AND SCOPE:

Patients must be referred by a GP, dentist, school dental therapist, consultant or house surgeon.
Criteria for referral:
• Medically, intellectually or financially compromised
• Requiring treatment in a hospital setting
• Facial fractures and laceration (not tumorous)
• School aged pupils under 18 years.

SPECIFIC REFERRAL INFORMATION:

Community Card holder number.

TESTS REQUIRED:

Nil.

OTHER INFORMATION:

Nil.

CONTACT:

Phone: (06) 350 8610 Postal: Ambulatory Care Centre
E-mail: ambulatorycare@midcentral.co.nz Palmerston North Hospital
Private Bag 11036
Palmerston North
**ASSESSMENT CRITERIA FOR FIRST SPECIALIST ASSESSMENT (ACA)**

**Category Definitions:** These are recommended guidelines for HHS specialists prioritising referrals from primary care.

1. Immediate - within 24 hours
2. Urgent - within 2 weeks
3. Semi-urgent - within 8 weeks
4. Routine - within 24 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Example (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>• Significant or uncontrolled bleeding</td>
<td>The following factors may modify a category: Age Criteria may have more importance in an infant or a frail elderly patient.</td>
</tr>
<tr>
<td></td>
<td>• Severe poorly controlled pain</td>
<td><strong>Associated Medical Condition.</strong> Medically compromised patients require enhanced priority.</td>
</tr>
<tr>
<td></td>
<td>E.g. Acute trigeminal neuralgia</td>
<td><strong>Social/Family Circumstances</strong> may require conditions to be managed more acutely.</td>
</tr>
<tr>
<td></td>
<td>• Life threatening conditions</td>
<td><strong>Dental Treatment Prior to Other Acute Medical Intervention.</strong></td>
</tr>
<tr>
<td></td>
<td>E.g. Ludwigs Angina</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Acute and significant functional impairment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E.g. acute bilateral TMJ dislocation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Severe/acute oral medical conditions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E.g. Primary herpetic stomatitis.</td>
<td></td>
</tr>
<tr>
<td>2. Urgent</td>
<td>• Suspected malignancy.</td>
<td>• Ulcer in the mouth lasting longer than 10 days</td>
</tr>
<tr>
<td></td>
<td>• Swelling/pain.</td>
<td>• Oral/facial lumps increasing in size</td>
</tr>
<tr>
<td></td>
<td>• Oral/facial trauma not requiring immediate treatment.</td>
<td>• Trigeminal neuralgia</td>
</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>• Pain, adequately controlled.</td>
<td>• TMJ dysfunction</td>
</tr>
<tr>
<td></td>
<td>• Facial/jaw cyst.</td>
<td>• Dentigerous cysts, keratocysts</td>
</tr>
<tr>
<td></td>
<td>• Chronic infections.</td>
<td>• Sinus pathology</td>
</tr>
<tr>
<td></td>
<td>• Salivary gland pathology.</td>
<td>• Ostemyelitis</td>
</tr>
<tr>
<td></td>
<td>• Routine care for medically compromised patients.</td>
<td>• Pleomorphic adenoma</td>
</tr>
<tr>
<td>4. Routine</td>
<td>• Oral medical conditions.</td>
<td>• Lichen Planus</td>
</tr>
<tr>
<td></td>
<td>• Congenital conditions/malformations.</td>
<td>• Pemphigus</td>
</tr>
<tr>
<td></td>
<td>• Cranio-facial rehabilitation.</td>
<td>• Aphthous ulceration</td>
</tr>
<tr>
<td></td>
<td>• Routine dental care.</td>
<td>• Zerostomos</td>
</tr>
<tr>
<td></td>
<td>• Non-malignant growths.</td>
<td>• Prognathism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Branchial arch abnormalities</td>
</tr>
</tbody>
</table>
DERMATOLOGY

FOCUS AND SCOPE:
Assessment, education and treatment of dermatological conditions, particularly those of a chronic nature.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Full medical history, list of treatments tried, findings, social impact of disease.

CONTACT:
Phone: (06) 350 8610
E-mail: ambulatorycare@midcentral.co.nz
Postal: Ambulatory Care Centre
        Palmerston North Hospital
        Private Bag 11036
        Palmerston North
# DERMATOLOGY

National Access Criteria for First Assessment [ACA]

**Category Definitions**: These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Urgent**  - within 1 week
   - Haemodynamically unstable dermatoses
   - Severe skin infections
   - Severe bullous diseases
   - Hospitalisation likely

2. **Semi-Urgent**  - within 4 weeks
   - Suspected melanoma
   - Extensive inflammatory dermatoses
   - Infectious dermatoses
   - Rapidly enlarging skin tumours
   - Dermatoses causing significant distress or preventing work
   - Adverse drug reactions

3. **Routine**  - within 16 weeks
   - Sun damage
   - Stable dermatoses causing distress
   - Minor skin infections
   - Congenital skin disorders

4. **Will not be seen**
   - Venous ulceration
   - Sexually transmitted diseases
   - Minor cosmetic conditions
   - Boasting allergy

**Examples (not an exhaustive list)**

- Frythodema, generalised pustular psoriasis
- Eczema herpeticum
- Erythema multiforme, pemphigus, pemphigoid, TEN
- Melanoma
- Psoriasis affecting >5% body surface area
- Impetiginised eczema, scalp ringworm
- Keratoacanthoma, SCC on lip/ear
- Acute contact dermatitis, facial rashes, nodulocystic acne
- Toxic erythema
- Actinic keratosis, basal cell carcinoma
- Stable psoriasis, acne, eczema, verruca skin condition, allergic contact dermatitis
- Port wine stain, inherited ichthyosis, congenital nevus
- Refer to vascular surgeons; may be seen in special circumstances such as ulcers unresponsive to conventional treatment or those possibly complicated by contact dermatitis reaction or malignancy
- Refer to sexual health clinic
- Wrinkles, tattoo, benign mole for cosmetic removal, skin tags, untreated warts
- Spider naevi, sporoblastic keratoses

**Note:**

- Depending on facilities available skin cancers are dealt with either at the initial consultation or are booked at a surgical procedure clinic. This may include removal of large or multiple tumours/flaps/grafts or even Mohs's surgery. When more complex intervention is required or facilities are not available, appropriate referral is made.
- Patients presenting with serious acute skin conditions when a dermatologist is unavailable should be managed by the on-call medical or surgical team as appropriate and referred to dermatologists (with reference to the above criteria) for subsequent management.
- Children falling into category 1 need to be referred immediately to a paediatric service for assessment, as many of these conditions will require hospital admission.
# Dermatology

National Clinical Priority Assessment Criteria [CPAC]

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
</table>
| 1. Immediate | • Haemodynamically unstable dermatoses  
• Severe skin infections  
• Severe bullous diseases | • Erythroderma, generalised pustular psoriasis  
• Eczema herpeticum, severe Herpes simplex  
• Erythema multiforme, pemphigus, pemphigoid, TEN |
| 2. Semi-Urgent | • Suspected melanomas or other rapidly enlarging skin tumours  
• Dermatoses causing significant distress or preventing work  
• Skin biopsy for diagnostic purposes | • Melanoma, keratoacanthoma, SCC  
• Eczema, psoriasis, hand dermatitis |
| 3. Routine   | • Sun damage  
• Atypical Naevi  
• Stable dermatoses causing distress  
• Investigations of skin disorders | • Actinic keratosis, basal cell carcinomas, SCC  
• Atypical naevi for removal  
• Eczema, psoriasis, vitiligo  
• Skin biopsy, patch tests, phototesting, etc |
| 4. Staged    | • Episodic skin conditions  
• Birthmarks | • Polymorphic light eruption (PUVA), Raynaud’s phenomena (Iloprost infusion)  
• Congenital naevi, superficial vascular malformations, haemangiomas |

Note:
- Where facilities are available most skin conditions are treated at the initial consultation. The main booked treatment procedures are phototherapy, surgical excisions and cryotherapy.
- Superficial vascular malformations are managed according to the Core Health Services criteria.
FOCUS AND SCOPE:
Focus: Assessment, diabetes education, clinical management and crisis intervention for people with diabetes.
Scope:
- Type 1 diabetes at diagnosis or ongoing problems
- Type 2 diabetes with more complex needs beyond scope of primary health care.
- Pregnancy diabetes care – pre-existing Type 1 or 2
  - Preconception planning or
  - Confirmation of pregnancy or gestational diabetes

SPECIFIC REFERRAL INFORMATION:
- Detailed history of blood-glucose monitoring results
- Current diabetes medications
- Other medical conditions and medications
- Recent investigations e.g. HbA1c.
- See referral form

TESTS REQUIRED:
Must have an established diagnosis of diabetes and details of this are required. Recent HbA1c, renal, liver functions and lipid profile is also required.

OTHER INFORMATION:
People who are referred to Diabetes Lifestyle Centre are usually seen by both nurse and dietician depending on reason for referral.
People may be referred on to the Diabetes Specialist Physician, Podiatrist or other services as required.

CONTACT:
Phone: (06) 350 8114  
Postal: 75 Heretaunga Street  
Fax: (06) 350 8128  
Palmerston North  
E-mail: comhlthreferral@midcentral.co.nz

HOURS OF ATTENDANCE:
8.30 am – 4.30 pm, Monday to Friday.

ACA criteria also apply to Diabetes Lifestyle Centre.
# National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Immediate** - same day
   - Newly diagnosed patients
     - All Type 1 patients
     - Type 2 patients with:
       1. Significant hyperglycaemia and normal BMI and BS > 25 mmol/L or more
       2. Ketouria, 1+ or greater
       3. Significant intercurrent illness
       4. Complications at time of diagnosis
       - Acute Visual loss
       - Diabetic Foot Uteation
     - Associated cellulitis
     - Systemic symptoms of infection
     - Infection not responding to oral antibiotics
     - Radiological evidence of bone involvement

2. **Urgent**
   - Pregnancy
     - Women with either gestational diabetes or known diabetes
   - Diabetic Foot Uteation
     - Non healing and non-superficial ulceration
     - Associated peripheral vascular disease
   - High risk diabetic retinopathy
     - Direct referral to ophthalmology

3. **Semi-Urgent**
   - Glycaemic Control
     - HbA1c > 10% for 3 months
     - Serum creatinine > 200mol/L
   - Diabetic Nephropathy
   - Painful peripheral neuropathy
   - Newly diagnosed Type 2 patient with significant complications of diabetes
   - Pregnancy management
     - Hypoglycaemia
     - With unawareness
     - Use of glucagon > 2 times in 1 month

4. **Routine**
   - Glycaemic Control
     - HbA1c 8-10% for > 6 months
     - HbA1c 7-8% for > 12 months
   - Diabetic Nephropathy
     - Raised serum creatinine but < 200mol/L
     - Increasing urine albumin:creatinine ratio
     - Blood pressure target not attained
   - High risk diabetic foot (see core guidelines)
   - Hypoglycaemia
   - Hyperlipidemia and Hypertension
   - Shared care
   - Not meeting semi-urgent criteria
   - See referral guidelines

**Note:**
- Diabetes education including dietitian input, Retinal screening and Podiatry are an essential part of the primary-secondary collaborative team management of diabetes.
- Liaison with General Practitioner will enhance individual patient management.
National Clinical Priority Assessment Criteria [CPAC]

**Insulin Pump Therapy (Continuous Subcutaneous Insulin Infusion Therapy)**

A. Selection Criteria*
1. Patients with Type 1 diabetes with hypoglycaemic unawareness
2. Patients with Type 1 diabetes suffering recurrent severe hypoglycaemic episodes
3. Patients with Type 1 diabetes with poor glycaemic control and unacceptable fasting blood glucose levels due to a marked dawn phenomenon
4. Patients with Type 1 diabetes with poor glycaemic control despite multiple daily injections who are proven to have improved control with a trial of insulin pump therapy
5. Patients with Type 1 diabetes & recurrent DKA despite all efforts to avoid DKA
6. Patients with Type 1 diabetes with eating disorders (in highly selected cases)

B. Patient Requirements
1. Monitor and record blood glucose a minimum of four times per day, and make appropriate adjustments
2. Responsible and psychologically stable
3. Willing to quantitate food intake
4. Willing to comply with medical follow-up

C. Diabetes Service Requirements
1. Diabetes Nurse Educator trained in insulin pump therapy
2. Diabetes specialist with experience in the selection and supervision of patients on CSII
3. A dietitian with experience in providing appropriate dietary education for patients planning to use CSII
4. A detailed programme for pre-CSII review, implementation, support and on-going review of patients on CSII
5. Ability to provide a trial period of pump therapy to suitable patients

* Taken from: Continuous Subcutaneous Insulin Infusion Pump therapy (CSII) Dunn, Von Roitzstein NZSSD May 1999
FOCUS AND SCOPE:
Dietitians advise and consult on the nutritional treatment, management and prevention of diseases and their symptoms, in the inpatient and outpatient setting, based on biochemistry and other diagnostic information. Dietitians ensure the provision of appropriate therapeutic diets for inpatients and arrange supply of required nutritional products, where indicated, on discharge. Dietitians consult and provide education incorporating evidence based research and best practice.

SPECIFIC REFERRAL INFORMATION:
Any patient who fits the referral criteria requiring nutritional assessment and/or intervention can be referred to the Dietitian. Referrals should be made as early as possible so appropriate interventions can be implemented to ensure best outcomes. All referrals should be made on the generic MCH Referral Form, indicating if the patient is to be seen as an inpatient or in the community (outpatient). If possible, at least 24 hours notice of discharge of inpatients should be given. Referral should state:
- Any relevant test results e.g. electrolytes, lipids, blood sugars, HbA1C, haemoglobin, LTT, albumin, weight, etc.
- Co-morbidities
- Medications
- Diagnosis
- Medical history
- Communication difficulties

NB: A patient meal request or note on Trendcare does not constitute a Dietitian referral.

REFERRAL CRITERIA:

INPATIENT
(All inpatient referrals will be seen, but relevant information must be included so patients can be prioritised correctly.)
The following types of patients may be referred.
- Existing or newly diagnosed diabetes
- Enteral feeding and TPN (must be referred)
- Co-morbidities associated with obesity
- Hyperlipidemia
- Swallow problems and dysphasia
- Abnormal biochemistry results indicating need of dietitian assessment
- Eating disorders (must be referred)
- Renal disease (must be referred)
- Cancer of the digestive tract, head or neck, or other areas associated with weight loss or eating difficulties
- Cystic fibrosis (must be referred)
- Surgery where the digestive tract is involved or there is a need for nutrient supplementation
• Severe wound healing problems
• PKU
• Paediatric patients with FTT (Failure to Thrive), IEM (Inborn Errors of Metabolism) and any other condition requiring dietitian input (must be referred)
• Allergies and intolerances (e.g. lactose, gluten)
• Hyperemesis
• Medical conditions affecting the digestive tract, food intake, and/or nutritional requirements (e.g. Crohn’s, CVA/Stroke)
• Existing intake of nutritional supplements (must be referred, patients will not receive supplements without a referral)

OUTPATIENTS

• We will accept all referrals from;
  o Consultants
  o Other health professionals employed under MCH
• All Eating disorders patients
• All paediatric patients
• Coeliac and Lactose intolerant referrals will only be seen when accompanied by the appropriate laboratory test results
• Patients with ongoing gastrointestinal symptoms
• Obesity patients will only be seen if they have existing co-morbidities
• Dyslipidaemia and Hypertension patients will be invited to attend a group cardiac education session
• Poor appetite patients will only be seen if they have a BMI <20 and unintentional weight loss of >10% in the past six months
• Diabetes patients should be referred to the Diabetes Lifestyle Centre

Other Information:
Dietitians are also involved with:
• In-service training to ward staff
• Cardiac Rehabilitation classes
• Outpatient clinics at Palmerston North, Dannevirke, Feilding, Pahiatua and Horowhenua

CONTACT:
Clinical Dietitians:
Phones: (06) 350 8864
Fax: (06) 350 8861
Postal: Ambulatory Care Centre
       Palmerston North Hospital
       Private Bag 11036
       Palmerston North

HOURS OF ATTENDANCE:
Monday to Friday – 8:00 am to 4:30 pm
Weekends – There is no Dietetic cover during weekends. Interim feeding regimes are available on each ward. Referrals may still be faxed as per protocol and will be seen on the next working day.
FOCUS AND SCOPE:
Specialist Community Nursing Service providing assessment and nursing interventions for patients in the following groups of patients:-
- Patients with health care needs that cannot be met by a generalist medical or nursing service alone
- Who, without provision of specialist nursing services, are at risk of further deterioration
- Whose health would not be further compromised by receiving care in the community

PURPOSE:
- Prevent avoidable admission to, or enable early discharge from hospital
- Minimise the impact of a personal health problem
- Provide support to people with long term or chronic personal health problems
- Promote self care and independence
- Provide terminal/palliative care in the community
- Improve the health of Maori and Pacific Island people

The District Nursing Service generally provides episodic, intensive, and short term care and works in partnership with patients, their families and other health care providers in order to optimise continuity of care across the continuum. Services are co-ordinated in Palmerston North with bases in Feilding, Levin, Otaki, Pahiatua and Dannevirke. The service operates 24 hours a day, 7 days a week and may be accessed by an 0800 telephone number.

SPECIFIC REFERRAL INFORMATION:
Phoned referrals are encouraged but emailed or faxed referrals are also received as below:
- **General history**: of current problem, services in place, risks/hazards to patient, family or visiting health professionals, current treatment, relevant investigations.
- **Interventions requested**
- **Wounds history** and current treatment and products
- **Continence**: MSU results, current treatment and any other relevant investigations
- **IV Therapy**: Phone DNS for instructions
- **Medication**: where administration is requested a prescription must accompany the referral.

OTHER INFORMATION:
District Nurses are available for phone consultation at any time on (06) 350-8100

CONTACT:
Phone:  (06) 350 8182 or 0800 001 491  Postal:    District Nursing Service
Fax:     (06) 350 8102            Private Bag 11036
Email:   districtnursingreferrals@midcentral.co.nz  Palmerston North Hospital
**DISTRICT NURSING**

Providing a range of nursing care for patients in the MDHB region 24 hours, 7 days a week

<table>
<thead>
<tr>
<th>SPECIALISED NURSING</th>
<th>ACC HOME NURSING</th>
<th>PALLIATIVE CARE</th>
<th>HOSPITAL IN THE HOME (HITH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient under the care of GP</td>
<td>Patient under the care of GP</td>
<td>Patient under the care of Arohanui Hospice and GP</td>
<td>Patient under care of hospital medical specialist</td>
</tr>
</tbody>
</table>

**Entry Criteria**
- Specialised nursing need that cannot be managed safely by GP, practice nurse or other carers
- Injury related accident with nursing needs
- Palliative care needs
- Patient medically stable. Patient, carer, District Nurses and specialist agree to care being provided at home. Patient has transport and telephone.

**Care Provided**
- **SPECIALISED NURSING**
  - Assessment
  - IV therapy
  - Acute complex wounds
  - Chronic wounds & leg ulcers
  - Continence/Ostomy
  - Rehabilitation
  - Acute personal care
  - Palliative care (non-Hospice)
  - Chemotherapy monitoring
  - Medication management
  - Gastrostomy management
  - Other short term acute needs

- **ACC HOME NURSING**
  - IV therapy
  - Wound care
  - Continence management
  - (not personal cares refer to ACC)

- **PALLIATIVE CARE**
  - Symptom management – pain, nausea, vomiting, pressure area care
  - Personal care
  - Psychological support
  - Family support
  - Bereavement support

- **HOSPITAL IN THE HOME (HITH)**
  - IV therapy – fluids and medication for treatment of Hyperemesis, TPN treatment of chronic diseases
  - Management of neutropenia
| To refer patients for Specialised Nursing, ACC Home Nursing, Palliative Care, contact |
| **District Nursing Referral Service, phone 8182, fax 8102** |
| (using Specialised Nursing and Allied Health Referral Form [730209]) |

| To discuss complex patients or request District Nurse |
| Involvement in family/multidisciplinary meeting, contact |
| **Charge/Associate Charge Nurse, District Nursing Service, phone 8100** |

| To discuss referral to Hospital in the Home, or the Community IV Therapy Service, contact |
| **Hospital to Community Nurse, phone 8333, pager 107** |
| (Mon-Fri 0830-1540 hrs) |
| Or **District Nursing Service, phone 8100** (weekends and after hours) |
ECG

FOCUS AND SCOPE:
Taking ECG recordings for people referred with cardiac or related conditions.

SPECIFIC REFERRAL INFORMATION:
Include BP and medications and patient’s build on referral.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 7122
Postal: Palmerston North Hospital
(06) 350 8611
Private Bag 11036
Fax: (06) 350 8641
Palmerston North

HOURS OF ATTENDANCE:
8.30 am – 5.00 pm.
ECHOCARDIOGRAPHY

FOCUS AND SCOPE:
All echocardiography requests and transoesophageal echocardiography (in consultation with either of the two Cardiologists only).

SPECIFIC REFERRAL INFORMATION:
• Referrals to be made on ultrasound referral form
• Current clinical details
• Murmurs of unknown origin
• Congestive Heart Failure
• Shortness of breath of unknown cause
• Known heart disease and/or congenital abnormalities.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 356 9169 ext 8280
Fax: (06) 350 8068
Postal: Palmerston North Hospital
        Private Bag 11036
        Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 4.00 pm, Monday to Friday.
EEG DEPARTMENT

FOCUS AND SCOPE:
Recording EEG (nerve conduction studies) for patients referred with neurological or related conditions.

SPECIFIC REFERRAL INFORMATION:
Nil.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
EEG do not require specialist approval
EMG do require specialist approval.

CONTACT:
Phone: (06) 350 8612
Fax: (06) 350 8642
Postal: Palmerston North Hospital
Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 4.30 pm, Monday to Friday.
ELDERHEALTH SERVICES  
(INCORPORATES GERIATRIC & PSYCHOGERIATRIC MEDICINE)

FOCUS AND SCOPE:

- People over the age of 65 with age-related problems requiring Assessment,
  Treatment and Rehabilitation Services. 
Age related problems including: Psychogeriatric disorders such as dementia, delirium 
and functional psychiatric disorders complicated by age-related physical disorders in 
those over 65 years. 

**Patients with terminal illness, needing palliative or hospice care, chronic 
pain syndrome and non age-related illness in a normally independent 
elderly person should be referred to other more appropriate services.**

SPECIFIC REFERRAL INFORMATION:

We need to have the name, address and telephone number of a family 
member/advocate if the patient referred has memory impairment, reduced insight or 
communication problems.

Consent of patient or person with Enduring Power of Attorney for individual to receive 
services.

Details or copies of recent and previous relevant investigation results and dates should 
be provided.

Details (or copies of letters) of other relevant DHB or private specialist assessments 
avoid unnecessary repeat investigations and examination.

An assessment of cognition (if available).

A list of the individual’s current medication.

If there have been trials of psychotropic medication, please give details of dose, 
duration and any adverse effects.

Domiciliary visits may be preferred, especially where the individual is very frail, in 
institutional care of where a visit to the home will significantly enhance the assessment. 
If a domiciliary visit is requested, please state reason.

If the person has previously received intervention/support related to disability support 
services or other community health services, then this information should be conveyed 
in the referral letter.

TESTS REQUIRED:

Full blood screen.

OTHER INFORMATION:

Early referral of individuals with dementia or other cognitive impairment is welcomed 
for diagnosis confirmation and for treatment and management options to be planned 
with family members, general practitioner and other community support services.
Community referrals will be seen in timely manner in response to urgency indicated in referral details. Individuals may be assessed in Emergency Department, as an outpatient, or as a domiciliary visit where there is a specific request by the General Practitioner (between 8.00 am – 5.00 pm, Monday to Friday).

Direct admissions will always be accepted, according to bed availability and need at Palmerston North and Horowhenua Hospitals.

Patients less than 65 years of age should INITIALLY be referred to an appropriate general/subspeciality medical service, mental health or Rehabilitation Services. If appropriate, a secondary referral will then be made to ElderHealth.

REFERRAL FOR DISABILITY SUPPORT SERVICES:

Self referrals or referrals by others including families, caregivers, general practitioners and allied health professionals should be sent to SupportLinks in the first instance.

Assessment of need for access to disability support services is undertaken by SupportLinks by means of Support Needs Assessment Form (SNAF).

After the SNAF is completed, SupportLinks may recommend a specialist ElderHealth assessment (SEA) is completed by ElderHealth Medical, Nursing or Therapy staff if there are treatment or rehabilitation opportunities which may improve health and reduce disability.

CONTACT:

Consultant staff are available for telephone consultations at any time. Telephone (06) 356 9169 and ask for the Consultant to be tele-paged.

Postal: ElderHealth
Palmerston North Hospital
Private Bag 11036
Palmerston North
FOCUS AND SCOPE:

The Palmerston North Emergency Department provides:

- A 24 hour trauma centre for the greater Manawatu region
- Acute assessment and initial management facility for primary health providers and self referrals for the Manawatu region (with some cross boundary flows, predominantly from Wanganui).
- The Transit Lounge – this facility assists in the observation of those patients who have been assessed in the Emergency Department as requiring observation (for a period of up to four hours), but do not require inpatient admission. It is also where patients who are assessed within the Emergency Department as being suitable for referral to the Hospital in the Home Service, have their initial treatment.

SPECIFIC REFERRAL INFORMATION:

Detailed information relevant to the current illness or injury (refer National Referral Guidelines).
For rest home residents more detailed medical history.
Patients not for referral to registrars should be notified to the Triage Nurse or discussed with Emergency Department medical staff.
Hospital in the Home patient referrals accepted only during working hours, i.e. 8.00 am – 5.00 pm.

TESTS REQUIRED:

- Those relevant to the presenting symptoms (refer National Referral Guidelines).
- If any investigations have been arranged, copies of original full results should accompany referral.

OTHER INFORMATION:

For those patients that fall into the category of triage level five (non urgent), there may be some time delays in being seen. For those patients, it would be quicker if they sought medical attention elsewhere.
An Acute Medical Assessment Clinic is available Monday to Friday located in the Ambulatory Care Centre, Palmerston North Hospital (see “Acute Medical Assessment Clinic” section) where it may be more appropriate to refer medical patients who require urgent assessment.
For those patients not admitted, a copy of the computerised clinical chart and ACC form where relevant, is posted to the general practitioners.
The RCIN daily report received by GPs also records summarised ADT information.

ACCESSING HOSPITAL DISCIPLINES/SPECIALITIES FOR REFERRALS:

All ACUTE referrals, regardless of speciality are sent to ED, unless stated otherwise in the guidelines (e.g. Maternity).
A referral letter is to be provided, preferably by accompanying the patient.
Clarify as to whether the referral is for advice or to be seen and assessed.
The process for referring should be by telephone to the duty speciality service Registrar.
If the Registrar is unavailable:
• If in Operating Theatre – ask to be put through to the theatre and discuss case via the speaker system
• The ED Consultant
• The ED Triage Nurse. Clarify who the recipient of the referral needs to be.

CONTACT:

Non-urgent or second opinion referrals are to be referred, in written format, to the appropriate clinic/speciality via the Ambulatory Care Centre.

Emergency Department: (06) 357 5811
Triage Nurse: (06) 350 8755
Fax: (06) 350 8172
Email: emergency.department@midcentral.co.nz
PNH Telephone Operator: (06) 356 9169

CONTACT:

For medical patients who require urgent assessment, an Acute Medical Assessment Centre is available Monday to Friday (see “Acute Medical Assessment Clinic” section).

Phone: (06) 350 8611
Fax: (06) 350 8641
Email: ambulatory.care@midcentral.co.nz
FOCUS AND SCOPE:
Enable New Zealand is a multi-service organisation working to assist disabled people, their families/whanau/hapu, employers, health professionals and disability support organisations.

*Our vision is that people we serve enjoy the best opportunities to live well in their community.*

Enable New Zealand manages health and disability funding intended to improve the quality of life of disabled people. This is achieved by providing access to information, research, funding or equipment, housing alterations, vehicle purchase and modifications, and needs assessment with service co-ordination.

*Enable New Zealand will facilitate and deliver quality access to resources for people with identified health and disability support needs.*

Some of the services managed by Enable New Zealand, such as Enable Information, are available nationwide whilst other services are provided regionally as contracted by the Ministry of Health, ACC or District Health Board.

Enable New Zealand’s head office is located in Palmerston North with offices in Hamilton, Lower Hutt and Christchurch. Enable New Zealand manages the local needs assessment and service co-ordination provider, Supportlinks, who also have a presence in Dannevirke and Horowhenua.

CONTACT:
CallFree: 0800 ENABLE (362 253)  Postal: Enable New Zealand
Fax: (06) 353 5876  69 Malden Street
Email: enable@enable.co.nz  PO Box 4547
Website: www.enable.co.nz  Palmerston North

ENABLE INFORMATION:
Enable Information is a national disability information and referral service that assists disabled people, health professionals and disability support services to access quality information.

Call us for:
**Equipment**
- Information on equipment and suppliers
- Where to hire disability equipment
- Sources of funding

**Disability Support Services**
- Contact details for services providing disability support

**Assessment Services**
- Who to contact for an assessment (equipment, housing, help at home)
Library Resources
- Books available for loan
- Information on legislation & standards
- Contacts for other disability libraries

Other Information
- Research on disability & rehabilitation
- Health conditions & disability information
- Mobility and transportation

*Easy access to quality information empowers disabled people and supports their autonomy.*

Databases available on the Internet
- Equipment database
- Secondhand equipment database
- Hire equipment database
- Library and journal databases

**CONTACT:**
Phone:  (06) 353 5810  
Fax:  (06) 353 5876  
CallFree:  0800 17 1981  
Email:  info@enable.co.nz  
Website:  www.enable.co.nz

**ENABLE STORES:**

The Service
Enable New Zealand is contracted by the Hamilton, Wellington and South Offices of the Ministry of Health to provide a reissue store for returned and bulk purchased items of equipment. Enable Stores are based in Palmerston North and Christchurch.

All items of equipment purchased for people who meet the Ministry of Health criteria are the property of the Ministry of Health and are provided for the sole use of the person with the disability for as long as they meet the relevant criteria.

To obtain these services a person requires an assessment conducted by a Specialised Assessor. The Specialised Assessor will work together with the person to identify the most appropriate solution to meet the essential disability related need.

Enable Stores holds a wide range of disability and rehabilitation equipment. Once a requisition for equipment has been made by a Specialised Assessor, Enabled Stores will arrange the freight of the equipment to the specified delivery address. When the equipment is no longer required Enable Stores can be contacted to arrange the freight back to the store.
Returned equipment is cleaned and repaired (where necessary) and becomes available for reissue.

CONTACT:
FaxFree: 0800 17 1996
Postal: Enable Stores
Enable New Zealand
69 Malden Street
PO Box 4547
Palmerston North

WHEELCHAIR AND SEATING OUTREACH SERVICE:
This is a resource for disabled people and their wheelchair and seating assessors. It gives easy access to wheelchair and seating product and support for assessment. Referrals are made after the specialised wheelchair and seating assessor has worked with the disabled person to complete an assessment. The referral includes background, social, occupational and clinical information. Goals for mobility and seating are stated. The Specialised Assessor gives an indication of the disabled person’s needs in wheelchair, cushion, back or seating system and identifies any accessories required and the reason for them.

The service offers:

• Disabled people a co-ordinated and speedier service for trial of wheelchair and seating options
• Outreach appointments at a wheelchair accessible venue
• Co-ordination of requested product from multiple suppliers (available at one place at one time)
• Access to information on possible alternative product
• Technician support
• Advice and support from a co-ordinator who is an Occupational Therapist
• Supplier support
• Easy access to recycled equipment and components for trial
• Support when funding application decisions are difficult or unpopular
• Availability of pressure mapping to assist in choice of cushions and backs
• Access to specialised seating system assessments

The role of the Wheelchair and Seating Outreach Co-ordinator:

• Contacting Reissue Store about availability of reissuable assets prior to trial of new product
• Contacting various suppliers to arrange product options for trial on one day
• Being a technician as well as a therapist
• Being the sole source of knowledge about products
• Signing off for invoicing
Using the Outreach Service can add value in the following ways:

- Reduction in Specialised Assessor time
- Nothing is too simple or too complex – any wheelchair or seating options are considered
- Opportunity for learning: New colleagues can come to acquire skills and knowledge
- Applications that are sent through the Outreach Service are assured of approval unless they cross the budget threshold
- Where it is appropriate or essential the outreach service can be mobile

CONTACT:

Email: processing@enable.co.nz
Website: www.enable.co.nz
Postal: Wheelchair and Seating Outreach Service
Enable New Zealand
13 Aglionby Street
Lower Hutt
(PO Box 38 847)
Wellington Mail Centre

ENABLE REHABILITATION:

The Service

Enable Rehabilitation, a service of Enable New Zealand, has been contracted by the Accident Rehabilitation Compensation Insurance Corporation (ACC) to provide equipment for ACC clients. Enable Rehabilitation provides equipment to assist people who have been disabled as the result of an accident.

Equipment for short or long term use is purchased, issue, recalled, refurbished and reissued.

We will arrange freight of equipment that needs to be returned to suppliers or our stores.

ACC equipment is stored in both Palmerston North and Christchurch.

How to apply

To access this service you must apply to ACC, either personally or by referral from a GP.

An ACC Case Manager will arrange for a health professional to assess your needs. You will be involved in the assessment, discussion on the range of suitable equipment and a trial will be arranged if necessary.

The assessor or ACC Case Manager will request provision of equipment to meet these needs.
Call us for:
- Information on how to apply
- Information on suppliers
- ACC Branch contact details
- Returning equipment for reissue

This service covers all New Zealand except Auckland, Northland and Waikato.

CONTACT:

CallFree: 0800 17 0091  
Phone: (06) 353 5850  
Fax: (06) 353 5877  
Email: acc@enable.co.nz  
Website: www.enable.co.nz

Postal: Enable Rehabilitation  
69 Malden Street  
PO Box 4547  
Palmerston North
FOCUS AND SCOPE:

Primarily focussed on assessment, investigation and treatment of Diabetes Mellitus and Thyroid disorders.

SPECIFIC REFERRAL INFORMATION:

Diabetes Mellitus:
• Detailed history and blood glucose monitoring results
• Current medication.
Thyroid problems:
• Detailed history.

TESTS REQUIRED:

Diabetes Mellitus:
• Glucose series.
Thyroid Problems:
• In vitro thyroid function tests.

OTHER INFORMATION:

Nil.

CONTACT:

Phone: (06) 350 8610
Postal: Ambulatory Care Centre
       Palmerston North Hospital
       Private Bag 11036
       Palmerston North
# Endocrinology

## National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Urgent** - at next clinic or within 1 week
2. **Semi-Urgent** - within 4 weeks
3. **Routine** - within 12 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
</table>
| 1. Urgent | • Severe weakness, dehydration, hypotension (Addison’s disease etc.)  
• High serum calcium > 3.0 mmol/L or symptoms  
• Severe hyperthyroidism  
• Hypo-hyperparathyroidism - severe  
• Progressive ophthalmopathy  
• Pituitary tumours |
| 2. Semi-Urgent | • Pituitary dysfunction  
• Adrenal dysfunction  
• Serum Calcium between 2.7 and 3.0 mmol/L  
• Goitre/thyroid enlargement  
• Hirsutism with testosterone > 5 mmol/L  
• Pagets disease |
| 3. Routine | • Carcinoid syndrome  
• Full range of endocrine disorders  
• Serum Calcium < 2.7 mmol/L  
• Hypo-hyperthyroidism  
• Goitre, thyroid nodules  
• Osteoporosis  
• Hirsutism  
• Hyperprolactinaemia < 2000  
• Hypogonadism |
| 4. Not Seen | • Simple obesity |
## Endocrinology

### National Clinical Priority Access Criteria (CPAC)

**Category Definitions:**
1. **Urgent**: within 60 minutes
2. **Semi-Urgent**: within 12 to 24 hours
3. **Routine**: within 2 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or emailed. The times to assessment may vary depending on caseload and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Urgent</td>
<td>• Severe physiological and metabolic dysfunction requiring major interventional management to prevent morbidity and mortality</td>
<td>• IV therapy (fluids, medications)\n• Monitoring cardiovascular, respiratory and biochemical</td>
</tr>
<tr>
<td>2. Semi-Urgent</td>
<td>• Extremes of age or disability with physiological and/or metabolic dysfunction requiring management intervention.</td>
<td>• Child IDDM - refer Diabetes guidelines\n• Frail, visually impaired elder\n• Intellectually disabled\n• Cognitive impairment</td>
</tr>
<tr>
<td>3. Routine</td>
<td>• Environmental control unobtainable in a community setting.\n• <em>Note</em>: in most situations environmental control should be managed in the community using diabetic nurse/dietician and other community health resources.\n• Inability to access appropriate investigations when needed.</td>
<td>• Metabolic investigations requiring controlled conditions\n• Metabolic re-stabilisation\n• Retraining\n• Chronic peripheral ulcers unresponsive to home care</td>
</tr>
</tbody>
</table>

*Version 1 Endocrinology National Referral Recommendations* • Date: 11/9/2000 • Authorised: Elective Services, HFA
ENT/ORL

FOCUS AND SCOPE:
A broad range of ENT/ORL and related problems.

SPECIFIC REFERRAL INFORMATION:
ACC fractures – if > 7 days refer to Private Practitioner
Industrial hearing loss – ACC form and referral to Private Practitioner.

TESTS REQUIRED:
Chest x-ray for cough.
Barium for dysphagia.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8610
Postal: Ambulatory Care Centre
        Palmerston North Hospital
        Private Bag 11036
        Palmerston North
GASTROENTEROLOGY REFERRALS

INDICATIONS FOR REFERRAL:

- Dysphagia
- Persistent indigestion
- Abdominal pain (6 weeks)
- Vomiting, anorexia
- Weight loss
- Haematemesis or melena
- Iron deficient anaemia
- Suspected celiac disease
- Chronic diarrhoea
- Inflammatory bowel disease
- PEG (Percutaneous Endoscopically placed Gastrostomy tubes)
- ERCP (Endoscopic Retrograde Cholangio Pancreatography)
- Liver disease (including Hepatitis B and C with deteriorating liver function)
- Pancreatic disease.
- Colonic disease especially characterised by:
  - PR bleeding with change in bowel habit to looser or increased frequency for 6 weeks (any age)
  - Palpable (definite) right sided abdominal mass (any age)
  - Palpable rectal mass (any age)
  - PR bleeding without anal symptoms (discomfort, itch, lumps, prolapse, pain) 60+ years
  - Change in bowel habit to looser or increased frequency without bleeding for 6 weeks 60+ years
  - Iron deficient anaemia without cause – males 110, females 100 (any age).

REQUIRED REFERRAL INFORMATION

1. Detailed history, and findings of examinations including:
   - previous surgery
   - previous endoscopies, abdominal Ultrasounds, and any other relevant investigations/examinations
   - BMI.
2. Blood tests ie FBC, Fe, B12, folate, endomysial antibodies, LFT’s, U&Es, TSH, Hep. B & C, INR, ESR, CRP.
3. All current medication including anticoagulants, iron tablets, codeine and non-steroidal anti-inflammatory drugs.
4. Referrals for any other specialist review or procedures, eg Barium studies/surgical referral.

It is critical that all of the above information is provided to allow accurate and timely prioritisation of your patients for endoscopic procedures.

Incomplete or declined referrals will be returned to you.

Referrals for patients outside of MidCentral DHB’s boundaries will be declined.

SEND TO:

– via green envelopes

Ambulatory Care Referral Office
PALMERSTON NORTH HOSPITAL
Private Bag 11036
PALMERSTON NORTH 4442

PLEASE DO NOT FAX REFERRALS
# Gastroenterology

**National Access Criteria for First Assessment (ACA)**

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

- **Acute:** after hours or next list but within 72 hours
- **Elective:** within 2 weeks
  - A/B: between 2 to 4 weeks
  - B: between 4 to 8 weeks
  - C: after 8 weeks
  - Nil: not defined.

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment/treatment may vary depending on size and staffing of the hospital department.

## NATIONAL REFERRAL GUIDELINES: COLONOSCOPY

<table>
<thead>
<tr>
<th>Indication</th>
<th>Priority</th>
<th>Acute</th>
<th>A/B</th>
<th>B</th>
<th>C</th>
<th>N/I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute lower gastrointestinal haemorrhage</strong></td>
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<tr>
<td>Continuous / unstable / &gt; 4 units of blood</td>
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<tr>
<td>Stable / requiring blood transfusion</td>
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<td>Stable / not requiring blood transfusion</td>
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<td>- All emergency colonoscopies should be performed after bowel preparation with colonic lavage given by nasogastric tube</td>
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<tr>
<td>Altered bowel habit / &quot;alarm&quot; symptoms</td>
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<td>Altered bowel habit / NO &quot;alarm&quot; symptoms</td>
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<tr>
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<tr>
<td>- Exclude ano - rectal cause</td>
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<td>- &quot;Alarm&quot; symptoms: weight loss, severe pain, anaemia</td>
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<td><strong>Iron deficient anaemia (No loading GI symptoms)</strong></td>
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<tr>
<td>Diarrhoea / Suspected I.B.D</td>
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<td>Diagnostic</td>
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<td>Extent</td>
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<tr>
<td><strong>Abnormal Barium enema</strong></td>
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<tr>
<td>Suspected cancer / large polyp &gt; 2cm</td>
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<td>Pseudo obstruction</td>
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<td>Personal history of colon polyp or cancer</td>
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<tr>
<td>Family history of colon cancer</td>
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<td>Ulcerative colitis</td>
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<td>- According to local/national guidelines</td>
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</tbody>
</table>

- Preferred priority for investigation
- Alternative priority for investigation
# Gastroenterology

## National Clinical Priority Access Criteria for Colonoscopy (CPAC)

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

**Emergency:** - AH - after hours  
- NL - next list  
**Elective:** - A - within 2 weeks  
- A/B - between 2 to 4 weeks  
- B - between 4 to 8 weeks  
- C - after 8 weeks  
- N/I - not indic.

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

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</tbody>
</table>

- Preferred priority for investigation  
- Alternative priority for investigation
**GASTROENTEROLOGY**

**National Access Criteria for First Assessment (ACA)**

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

- **Acute:** after hours or next list but within 48 hours
- **Priority:**
  - A: within 10 days
  - A/B: between 11 to 20 days
  - B: between 21 to 30 days
  - C: after 30 days
  - N/I: not indicated

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment/treatment may vary depending on size and staffing of the hospital department.

### NATIONAL REFERRAL GUIDELINES: GASTROSCOPY

<table>
<thead>
<tr>
<th>Indication</th>
<th>Acute</th>
<th>A/B</th>
<th>B</th>
<th>C</th>
<th>N/I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper gastrointestinal haemorrhage</strong></td>
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<tr>
<td>Continuous or early re-bleeding / unstable</td>
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<tr>
<td>&gt; 65 years of age and on NSAID</td>
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<tr>
<td>Chronic liver disease</td>
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<tr>
<td>Stable / haemoglobin &lt; 100g/L</td>
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<tr>
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<tr>
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<td><strong>Foreign body</strong></td>
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<tr>
<td>Battery in oesophagus</td>
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<tr>
<td>Other foreign body in oesophagus</td>
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<tr>
<td>Caustic burns</td>
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<tr>
<td>- If foreign body remains in oesophagus gastroscopy within 12 hours</td>
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<tr>
<td>- Caustic injuries should not be gastroscoped beyond 24-36 hours</td>
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<tr>
<td><strong>Dysphagia</strong></td>
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<td>Food bolus obstruction</td>
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<tr>
<td>&lt; 3 months, progressive</td>
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<td>&gt; 3 months, stable</td>
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<tr>
<td><strong>Dyspepsia / Heartburn</strong></td>
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<tr>
<td>&gt; 50 years OR &quot;alarm&quot; symptoms</td>
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<tr>
<td>all others</td>
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<tr>
<td>- Consult National Dyspepsia Guidelines</td>
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<tr>
<td>- &quot;Alarm&quot; symptoms, weight loss, anaemia, severe pain</td>
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<tr>
<td>- Gastroscopy preferably performed at least 3 weeks off active acid suppression</td>
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<tr>
<td><strong>Surveillance</strong></td>
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<tr>
<td>Barrett's surveillance</td>
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<tr>
<td>Gastroscopy surveillance</td>
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- Preferred priority for investigation
- Alternative priority for investigation
# Gastroenterology

## National Clinical Priority Access Criteria for Gastroscopy (CPAC)

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

- **Emergency:**
  - **AH:** after hours
  - **NL:** next list

- **Elective:**
  - **A:** within 10 days
  - **A/B:** between 11 to 20 days
  - **B:** between 21 to 30 days
  - **C:** after 30 days
  - **N/I:** not indic.

Immediate and Urgent cases must be discussed with the referrer or Registrar in order to get appropriate prioritization and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

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<td>Caustic burns</td>
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<tr>
<td>- If foreign body remains in oesophagus, gastroscopy within 12 hours</td>
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<td>- Caustic injuries should not be gastroscoped beyond 24-36 hours</td>
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<tr>
<td><strong>Dysphagia</strong></td>
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<tr>
<td>Food bolus obstruction</td>
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<tr>
<td>&lt; 3 months, progressive</td>
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<tr>
<td>&lt; 3 months, stable</td>
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<td>&gt; 3 months, stable</td>
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<tr>
<td>Longstanding, intermittent</td>
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<tr>
<td><strong>Dyspepsia / Heartburn</strong></td>
<td></td>
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<tr>
<td>&gt; 50 years OR alarm symptoms</td>
<td></td>
<td></td>
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<tr>
<td>All others</td>
<td></td>
<td></td>
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<tr>
<td>- Concur National Dyspepsia Guidelines</td>
<td></td>
<td></td>
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<tr>
<td>- &quot;Alarm&quot; symptoms: weight loss, anaemia, severe pain</td>
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<tr>
<td>- Gastroscopy preferably performed at least 3 weeks off active acid suppression</td>
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<tr>
<td><strong>Surveillance</strong></td>
<td></td>
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<tr>
<td>Barrett's surveillance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gastrectomy surveillance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- According to local/national guidelines</td>
<td></td>
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</tbody>
</table>

- Preferred priority for investigation
- Alternative priority for investigation
# National Access Criteria for First Assessment (ACA)

**Category Definitions**: These are recommended guidelines for HHS specialists prioritising referrals from primary care.

- **Acute**: within 12 hours
- **Priority**:
  - **A**: within 7 days
  - **A/B**: between 7 to 14 days
  - **B**: between 14 to 28 days
  - **C**: after 28 days

Immediate and urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment/treatment may vary depending on size and staffing of the hospital department.

## NATIONAL REFERRAL GUIDELINES: ERCP

<table>
<thead>
<tr>
<th>Indication</th>
<th>Acute</th>
<th>Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute cholangitis</strong></td>
<td></td>
<td></td>
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<tr>
<td>With septicaemia / not responding to therapy</td>
<td></td>
<td></td>
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<tr>
<td>With septicaemia / responding to therapy</td>
<td></td>
<td></td>
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<tr>
<td>Without septicaemia / responding to therapy</td>
<td></td>
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<tr>
<td>- Good, non-invasive imaging of liver and bile ducts essential prior to ERCP</td>
<td></td>
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<tr>
<td>- These criteria are also applicable to cholangitis due to blocked stents</td>
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<tr>
<td><strong>Acute - presumed biliary pancreatitis</strong></td>
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<tr>
<td>&gt; 3 Ranson (or equivalent) criteria</td>
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<td></td>
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<tr>
<td>Setting / &gt; 60 years of age and / or poor surgical risk</td>
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<tr>
<td>- Indication and timing of ERCP based on clinical presentation – consider early ERCP if suspected cholangitis associated with pancreatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post cholecystectomy complications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bile leak / suspected bile duct injury / patient unwell</td>
<td></td>
<td></td>
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<tr>
<td>Bile leak / suspected bile duct injury / patient well</td>
<td></td>
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<tr>
<td>Retained stone / symptomatic</td>
<td></td>
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<tr>
<td>Retained stone / asymptomatic</td>
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<tr>
<td><strong>Jaundice</strong></td>
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<tr>
<td>Progressive / painless / dilated ducts</td>
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<tr>
<td>Fluctuating or settling</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain – suspected biliary origin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected or proven choledocholithiasis</td>
<td></td>
<td></td>
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<tr>
<td>Suspected or known chronic pancreatitis</td>
<td></td>
<td></td>
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<tr>
<td>Suspected biliary dyskinesia</td>
<td></td>
<td></td>
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<tr>
<td><strong>Abnormal liver function tests</strong></td>
<td></td>
<td></td>
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<tr>
<td>Suspected sclerosing cholangitis</td>
<td></td>
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<tr>
<td>Suspected choledocholithias / no pain</td>
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</tbody>
</table>

- Preferred priority for investigation
- Alternative priority for investigation
# Gastroenterology

## National Clinical Priority Access Criteria for ERCP (CPAC)

### Category Definitions:
These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

- **Acute**
  - A
  - A/B
  - B
  - C
  - HL
  - AH

- **Elective**
  - A
  - A/B
  - B
  - C
  - U

Immediate and urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

### Indication

<table>
<thead>
<tr>
<th>Indication</th>
<th>Acute</th>
<th></th>
<th>Elective</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>AH</td>
<td>HL</td>
<td>A</td>
<td>A/B</td>
</tr>
<tr>
<td>Acute cholangitis</td>
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<tr>
<td>With septicemia / not responding to therapy</td>
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<tr>
<td>With septicemia / responding to therapy</td>
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<tr>
<td>Without septicemia / responding to therapy</td>
<td></td>
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</tr>
</tbody>
</table>
| - Good, non invasive imaging of liver and bile ducts essential prior to ERCP
  - These criteria are also applicable to cholangitis due to blocked stents |
| Acute presumed biliary pancreatitis     |       |          |          |          |          |          |
| > 3 Ranson (or equivalent) criteria     |       |          |          |          |          |          |
| Settling / > 60 years of age and / or poor surgical risk |       |          |          |          |          |          |
| - Indication and timing of ERCP based on clinical presentation - consider early ERCP if suspected cholangitis associated with pancreatitis |
| Post cholecystectomy complications     |       |          |          |          |          |          |
| Bile leak / suspected bile duct injury / patient unwell |       |          |          |          |          |          |
| Bile leak / suspected bile duct injury / patient well |       |          |          |          |          |          |
| Retained stone / symptomatic            |       |          |          |          |          |          |
| Retained stone / asymptomatic           |       |          |          |          |          |          |
| Jaundice                                |       |          |          |          |          |          |
| Progressive / painless / dilated ducts  |       |          |          |          |          |          |
| Fluctuating or settling                 |       |          |          |          |          |          |
| Pain - suspected biliary origin         |       |          |          |          |          |          |
| Suspected or proven choledocholithiasis  |       |          |          |          |          |          |
| Suspected or known chronic pancreatitis |       |          |          |          |          |          |
| Suspected biliary dyskinesia             |       |          |          |          |          |          |
| Abnormal liver function tests           |       |          |          |          |          |          |
| Suspected sclerosing cholangitis         |       |          |          |          |          |          |
| Suspected choledocholithiasis / no pain  |       |          |          |          |          |          |

- **AH** - Preferred priority for investigation
- **HL** - Alternative priority for investigation

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Version 1 Gastroenterology Referral Guidelines and Prioritisation Criteria | Date: 31/1/2001 | Authorised: Elective Services, HFA
# NATIONAL REFERRAL GUIDELINES: GASTROSCOPY

<table>
<thead>
<tr>
<th>Indication</th>
<th>Priority</th>
<th>Acute</th>
<th>A/B</th>
<th>B</th>
<th>C</th>
<th>N/I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper gastrointestinal haemorrhage</td>
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<tr>
<td>Continuous or early re-bleeding / unstable</td>
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<tr>
<td>&gt; 65 years of age and on NSAID</td>
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<tr>
<td>Chronic liver disease</td>
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<tr>
<td>Stable / haemoglobin &lt; 100g/L</td>
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<tr>
<td>Stable / minor episode</td>
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<tr>
<td>Iron deficient anaemia (No leading GI symptoms)</td>
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<tr>
<td>- Consider pre-hocking colonoscopy</td>
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<tr>
<td>Foreign body</td>
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<tr>
<td>Battery in oesophagus</td>
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<tr>
<td>Other foreign body in oesophagus</td>
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<tr>
<td>Caustic burns</td>
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<tr>
<td>- If foreign body remains in oesophage, gastroscopy within 12 hours</td>
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<tr>
<td>&lt; 3 months, progressive</td>
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<tr>
<td>&lt; 3 months, stable</td>
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<tr>
<td>&gt; 3 months, stable</td>
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<tr>
<td>longstanding, intermittent</td>
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<tr>
<td>Dyspepsia / Heartburn</td>
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<tr>
<td>&gt; 50 years OR &quot;alarm&quot; symptoms</td>
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<tr>
<td>- Consult National Dyspepsia Guidelines</td>
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<tr>
<td>- &quot;Alarm&quot; symptoms: weight loss, anaemia, severe pain</td>
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<tr>
<td>- Gastroscopy preferably performed at least 3 weeks off active acid suppression</td>
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<tr>
<td>Surveillance</td>
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<tr>
<td>Barrett's surveillance</td>
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<tr>
<td>Gastrctomy surveillance</td>
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- Preferred priority for investigation
- Alternative priority for investigation
GASTROENTEROLOGY

National Guidelines for Clinical Assessment (I)

Category Definitions: Those are recommended guidelines for health professionals referring patients for assessment/treatment in a HHS.

- **Admission**
  - A: within 24 hours
  - B: within 3 days

- **Outpatient**
  - A: within 1 week

- **Assessment**
  - A/B: between 1 to 3 weeks
  - B: between 3 to 10 weeks
  - C: within 24 weeks

- **Endoscopy**
  - Primary endoscopy preferred option

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>NATIONAL REFERRAL GUIDELINES: GASTROENTEROLOGY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indication</strong></td>
<td><strong>Priority</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Upper gastrointestinal haemorrhage</td>
<td>A</td>
</tr>
<tr>
<td>Dysphagia / Foreign body</td>
<td></td>
</tr>
<tr>
<td>Iron deficient anaemia (No GI symptoms)</td>
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<td></td>
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</tr>
</tbody>
</table>
  ∙ Consult gastroscopy guidelines
  
  ∙ For iron deficient anaemia: consider pre booking colonoscopy |  |  |  |  |  |  |
| Dyspepsia / Heartburn |  |  |  |  |  |  |
|  
  Not recently investigated
  
  Longstanding / recent gastroscopy |  |  |  |  |  |  |
|  
  ∙ Consult National Dyspepsia guidelines
  
  ∙ Also consult gastroscopy guidelines |  |  |  |  |  |  |
| Nausea / Anorexia / Weight loss |  |  |  |  |  |  |
| Abdominal Pain | A | B | A | A/B | B | C |
|  
  Suspected acute abdomen
  
  Short history / "alarm" symptoms |  |  |  |  |  |  |
|  
  Longstanding / no "alarm" symptoms
  
  + / - irregular bowel motions
  
  "Alarm" symptoms: weight loss, anaemia, severe pain |  |  |  |  |  |  |
| Diarrhoea |  |  |  |  |  |  |
|  
  Acute / dehydration
  
  Recent onset / with alarm symptoms |  |  |  |  |  |  |
|  
  Longstanding / no "alarm" symptoms |  |  |  |  |  |  |
| Constipation |  |  |  |  |  |  |
|  
  Recent onset / with "alarm" symptoms |  |  |  |  |  |  |
|  
  Longstanding / no "alarm" symptoms |  |  |  |  |  |  |

- Preferred priority for investigation

- Alternative priority for investigation

Version 1 Gastroenterology Referral Guidelines and Prioritisation Criteria • Date: 31/1/2001 • Authorised: Elective Services, HFA
### NATIONAL REFERRAL GUIDELINES: GASTROENTEROLOGY

<table>
<thead>
<tr>
<th>Indication</th>
<th>Priority</th>
<th>Addmission</th>
<th>Outpatient Assessment</th>
<th>Endoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rectal bleeding</strong></td>
<td></td>
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<tr>
<td>Acute lower GI haemorrhage</td>
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<tr>
<td>Recent onset / &quot;alarm&quot; symptoms / +/- change in bowel habit</td>
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<td>B</td>
</tr>
<tr>
<td>Longstanding / no &quot;alarm&quot; symptoms</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Consult colonoscopy guidelines</td>
<td></td>
<td></td>
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<tr>
<td><strong>Family history of bowel cancer</strong></td>
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<tr>
<td>- Consult local / national guidelines on screening and surveillance</td>
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<tr>
<td><strong>Jaundice</strong></td>
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<tr>
<td>Recent onset / &quot;hepatitis&quot; type / with &quot;alarm&quot; symptoms</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent onset / &quot;hepatitis&quot; type / NO &quot;alarm&quot; symptoms</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent onset / &quot;obstructive&quot; type / with &quot;alarm&quot; symptoms</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- &quot;Alarming&quot; symptoms: Prolonged INR, fever, abdominal pain, weight loss, confusion</td>
<td></td>
<td>A</td>
<td></td>
<td></td>
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<tr>
<td>- Consult ERCP guidelines</td>
<td></td>
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<tr>
<td><strong>Abnormal LFT's</strong></td>
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<tr>
<td>Recent onset / with &quot;alarm&quot; symptoms</td>
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<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longstanding OR incidental finding / NO &quot;alarm&quot; symptoms</td>
<td></td>
<td>A</td>
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</tr>
</tbody>
</table>

- Preferred priority for investigation
- Alternative priority for investigation
FOCUS AND SCOPE:

Adult:
Those medical patients with acute needs and/or uncertain diagnosis who do not require immediate admission, but who cannot wait for a normal urgent outpatient clinic. The service is targeted at those patients who would otherwise be referred to the Emergency Department for assessment.

SPECIFIC REFERRAL INFORMATION:
Referral letter containing current clinical details/test results. Remind patient to bring all current medications/x-rays.

CONTACT:
Phone: (06) 356 9169.

HOURS OF ATTENDANCE:
1.00 pm – 5.00 pm, Monday to Friday.

Please telephone the Physician undertaking the clinic for the day directly, via the hospital operator.
FOCUS AND SCOPE:
Adult:
Patients with non-acute internal medical conditions requiring specialist assessment and treatment. When possible, patients with problems that fall within the scope of a subspecialty clinic should be referred to that clinic.

SPECIFIC REFERRAL INFORMATION:
General description of current problem(s), background medical conditions and medication. Some indication of urgency is helpful to facilitate prioritising.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8610 (Clinic)  
Postal: Ambulatory Care Centre  
Palmerston North Hospital  
Private Bag 11036  
Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 5.00 pm.
## National Access Criteria for First Assessment [ACA]

**Category Definitions**: These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Urgent** - within 1 week
2. **Semi-Urgent** - within 4 weeks
3. **Routine** - within 8 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or emailed. The times to assessment may vary depending on size and staffing of the hospital department.

### NATIONAL REFERRAL GUIDELINES: GENERAL MEDICINE

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
</table>
| 1. Urgent | - Major clinical risk if treatment delayed.  
- Severe or progressive undiagnosed problem where condition potentially serious.  
- Uncontrolled, acute and/or severe symptoms and/or major functional impairment. | - Severe organ-specific disease with or without intercurrent significant other problems, eg RA + diabetes + COPD.  
- Potentially serious condition requiring diagnosis, eg ? Malignancy  
Refer to subspecialty criteria and examples. |
| 2. Semi-Urgent | - Unexpected deterioration of known condition.  
- Symptoms causing significant social / economic functional impairment.  
- GP diagnosis probable but further investigation/specialist confirmation required and condition potentially serious particularly if assessment/treatment is delayed.  
- Hospital admission possible if patient is not evaluated promptly. | - Unstable diabetes  
- Chest pain in professional driver falls/syncopeal episodes  
- TIA ? cause  
- Significant abnormal investigation result  
- Syndrome X (obesity, hypertension, gout, diabetes, heart failure)  
Refer to subspecialty criteria and examples. |
| 3. Routine | - Where wait time for specialist will not place the patient at risk of prolonged discomfort nor development of more serious symptoms/disease  
- Reassessment of known major/complex multisystem disorder. | - Chronic stable or slowly progressive condition.  
- Transfer referral from another centre.  
- Previously discharged from General Medical Service (GP and/or OGP)  
Refer to subspecialty criteria and examples. |

**Notes:**

- GP needs to be advised when appointment will occur. Significant change in condition should be notified to medical outpatients.
- GP can enhance referral process for urgent or complex cases via telephone consultation.
- Supporting communication by E Mail or fax should be considered.
- Consultant General Physicians with their breadth of knowledge, direct and co-ordinate the management of unsolicited or undifferentiated medical problems, particularly complex and multisystem disease. This service usually dominates in provincial centres though may work in parallel within subspecialty acute services in large centres.
- General Physician practice in nominated sub-specialties should be equivalent to subspecialty practice (though may lack the depth, eg Cardiology being subspecialty nominated, may not be trained in cardiac catheterisation). Peer recognition is expected, eg Membership of Subspeciality Society.

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Version 1 General Medicine Referral Guidelines and Prioritisation Criteria • Date: 20/1/2001 • Authorised: Effective Services, HFA
# General Medicine

## National Clinical Priority Assessment Criteria [CPAC]

**Category Definitions:**
1. **Immediate** - within 24 hours
2. **Urgent** - within 7 days
3. **Routine** - within 8 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

### National Referral Guidelines: General Medicine

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
</table>
| **1. Immediate** | - Severe acute illness of uncertain aetiology.  
- Severe acute illness with failure of one or more organ systems. | Refer AEP (Appropriateness Evaluation Protocol: RAND Update 1990) attached.  
Refer to subspecialty criteria. |
| **2. Urgent** | - Non acute unassessed major medical problem(s) with functional impairment and/or social and economic compromise.  
- Complex multisystem disease requiring inpatient management but without acute severe decompensation.  
- Transfers from other specialties/units. | • Frequent falls  
• Progressive breathlessness  
• Severe oedema  
• PUO, Syndrome X with decompensation  
Refer to subspecialty criteria |
| **3. Routine** | - Control of clinical condition unobtainable in a community setting.  
- Diagnostic or therapeutic procedure(s) | • Metabolic re-stabilisation eg diabetes.  
• Endoscopy, biopsy, IV therapy (note subspecialty criteria)  
• Intermittent Therapy  
Refer to subspecialty criteria. |

**Note:**
- The majority of inpatients within a General Medical Service are acute unselected admissions. Refer/cross reference to the subspecialty criteria.
- GP must be informed of acute assessment outcome in an appropriate timeframe (within 24 hours of discharge).
FOCUS AND SCOPE:
Assessment, investigation and treatment of patients referred with general surgical or related problem. 
See separate peripheral vascular surgery section for arterial or venous surgical problems.

SPECIFIC REFERRAL INFORMATION REQUIRED:
1. Seven classic features of a patient’s symptoms
2. Relevant positive and negative symptoms of the associated organ systems and Constitutional or general symptoms
3. Relevant medical and surgical history as well as family history, medications, adverse reactions to drugs, and relevant social information

NB
• A formal letter/MidCentral Health referral form detailing the above information is required. A (computer-generated copy) of serial consultation notes will NOT be accepted.
• Referral letters with inadequate information may be returned to the referrer.

A specialist general surgeon vets all referral letters into categories of Urgent, Semi-urgent or Routine. In general, urgent referrals will be seen within two weeks, semi-urgent within six weeks.

If you believe the referral needs very urgent clinic assessment, please either contact the specialist surgeon at surgical clinic, or the on-call surgeon, directly by telephone.

Notes on specific organ systems/problems pertaining to general surgery. This is NOT a comprehensive list:

General Surgery Exclusions:
• Investigation of weight loss or tiredness in the absence of specific symptoms or positive physical signs
• Cosmetic surgery
• Asymptomatic static benign skin or subcutaneous lesion or lump

1. Skin/subcutaneous lesions:
   • Focal lesions only
   • Exact description, size, site and, preferable, incisional biopsy to confirm, will help accurately prioritise referrals
   • Subcutaneous lipoma, sebaceous cysts and benign naevi/moles that are static and painless are of low clinical priority

2. Lymphadenopathy:
   • Pre-referral blood test results for full blood count, U & E, liver function test, ESR, C-reactive protein, Toxoplasmosis and Glandular Fever (if relevant), chest x-ray preferred.
   • DO NOT perform FNA or core biopsies prior to referral.
3. **Breast lump/pain/nipple discharge:**
   - >30 year old woman: pre-referral bilateral mammogram and breast ultrasound preferred.
   - **A normal mammogram does NOT exclude breast cancer in the presence of a palpable lump or nipple discharge:** general surgical clinic referral is still required.
   - DO NOT perform FNA or core biopsies prior to referral.

4. **Thyroid:**
   - Pre-referral blood test results for FT4 and TSH and calcium
   - Ultrasound scan preferred but not essential
   - DO NOT perform FNA or core biopsies prior to referral

5. **Salivary gland/neck lump:**
   - Ultrasound scan preferred but not essential
   - DO NOT perform FNA or core biopsies prior to referral

6. **Abdominal pain/Gastro-intestinal:**
   - History alone will give a diagnosis in 80% of patients
   - Pre-referral blood test results for full blood count, U & E, liver function test, ESR, C-reactive protein, routine urinalysis, and 3X faecal occult blood tests are essential
   - Dysphasia: send urgent referral to Gastroenterology for upper endoscopy, DO NOT refer initially to General Surgery Clinic

7. **Colorectal Symptoms: Including PR Bleeding:**
   - Detailed history and physical exam including rectal examination will give an accurate idea of urgency even if it does not give a diagnosis
   - Blood tests as above
   - 3X faecal occult blood tests, if no blood seen per anum
   - Barium enema if >35 years old, preferred but not essential

   **NB** A normal barium enema +/- rigid sigmoidoscopy does not exclude significant colorectal lesions or cancer in the presence of persistent symptoms in an adult, referral is still indicated.

8. **Gallstones, biliary tract, liver, pancreas:**
   - Cholecystectomy for gallstones is only considered if there is an accurate history of:
     - Biliary colic, acute cholecystitis, obstructive jaundice, or acute pancreatitis. Surgery would be considered for asymptomatic severely immuno-compromised patients with incidental gallstones on ultrasound scan.
     - Gallstones without referable symptoms in normal patients will not be treated surgically.
Abnormal liver function tests:

- If cholestatic or mixed abnormality:
  - Medical and surgical history including drugs and alcohol, liver/gall bladder/biliary/upper GI surgery
  - Pre-referral test results for previous liver function tests, full blood count, U & E, coagulation screen, Hepatitis titres incl. CMV, abdominal ultrasound scan, preferred.
  - Urgent referral to General Surgery esp. if mass lesion (s) are seen on Ultrasound scan
  - Urgent referral to Gastroenterology if previous gall bladder removal/biliary surgery as ERCP probably required.

- If hepatocellular abnormality:
  - Medical and surgical history including drugs and alcohol, liver/gall bladder/biliary/upper GI surgery
  - Essential pre-referral test results for previous liver function test, full blood count, U & E, coagulation screen, Hepatitis titres incl. CMV, ESR, CRP, autoimmune antibody screen, essential.
  - Abdominal ultrasound scan preferred.
  - Refer to Gastroenterology – see relevant referral guidelines.

Liver mass on ultrasound scan/CT scan:

- Urgent general surgical referral after assessments as above

9. Groin Lump/Abdominal wall hernia:

- A swelling isolated within the scrotum or testes, with a normal inguinal or groin area above, it is most likely a hydrocele or testicular mass: refer this to Urology.
- A swelling in the inguinal or groin area, with or without swelling in the scrotum, is most likely a hernia: refer this to General Surgery.
- A reliable history of an intermittent groin lump is most likely a groin hernia, even if no lump is detectable on examination.

Children's hernia:

- Refer groin lumps and uncertain groin/scrotal swellings to General Surgery.
- Umbilical hernia: 80% will spontaneously resolve before the age of 5 years, therefore only refer these if they persist at or over 5 years of age. These herniae rarely become incarcerated/obstructed.
PERIPHERAL VASCULAR SURGERY

FOCUS AND SCOPE:
Assessment, investigation and treatment of peripheral arterial and venous surgical disease.

SPECIFIC REFERRAL INFORMATION REQUIRED:
1. The seven classic features of a patient’s symptoms, in particular the degree, type and site of any pain.
2. Relevant positive and negative symptoms of the associated organ system as well as constitutional and general symptoms.
3. The extent of physical activity possible and what limits this.
4. Skin changes associated particularly chronic ischemic changes e.g. temperature difference, atrophy, condition of hair and nails, discolouration and ulcer.
5. Pulses: present and absent.
6. Relevant past medical and surgical history (especially cardio respiratory and diabetes), smoking, medications, adverse drug reactions, family history, relevant social information.

NB
- A formal referral letter/MidCentral Health referral form detailing the above information is required. A (computer-generated copy) of serial consultation notes will NOT be accepted.
- Referral letters with inadequate information may be returned to the referrer.
- Asymptomatic varicose veins or cosmetic varicose veins or those with no associated skin changes are of low priority.
- Intermittent claudication of >100m distance is generally of low priority.

Either a specialist vascular surgeon or a specialist general surgeon with an interest in vascular surgery vets all referral letters into categories of Urgent, Semi-urgent or Routine.

If you believe the referral needs very urgent clinic assessment, please either contact the specialist surgeon at surgical clinic, or the on-call specialist surgeon, directly by telephone.

CONTACT:
Phone: (06) 350 8610 Postal: Ambulatory Care Centre
E-mail: ambulatorycare@midcentral.co.nz Palmerston North Hospital
Postal: Ambulatory Care Centre
Private Bag 11036 Palmerston North
ASSESSMENT CRITERIA FOR FIRST SPECIALIST ASSESSMENT (ACA)
Clinical Priority Waiting Times for FSA:

<table>
<thead>
<tr>
<th>Clinical Priority for FSA</th>
<th>Category</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent</strong></td>
<td></td>
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<tr>
<td></td>
<td>Significant threat to life/ vital organ/ limb, if delayed management</td>
<td>Diagnosed general surgical malignancy (esp. melanoma, thyroid, breast, abdomen and digestive tract)</td>
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<tr>
<td></td>
<td></td>
<td>Children’s inguinal hernia</td>
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<td></td>
<td></td>
<td>Ischaemic or diabetic ulcer or rest pain in a limb</td>
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<td></td>
<td></td>
<td>Obstructive digestive tract symptoms</td>
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<tr>
<td></td>
<td></td>
<td>Abdominal aortic aneurysm</td>
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<tr>
<td></td>
<td>Alarm symptoms suggesting malignancy</td>
<td>New persistent Altered bowel habit and/ or rectal bleeding in adult &gt;40 years old</td>
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<tr>
<td></td>
<td></td>
<td>Breast lump in woman &gt;25 years old</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mole undergoing change</td>
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<tr>
<td></td>
<td></td>
<td>Head/ neck mass</td>
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<tr>
<td></td>
<td></td>
<td>Intra-muscular/ deep limb or trunk mass</td>
</tr>
<tr>
<td><strong>Semi-urgent</strong></td>
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<tr>
<td></td>
<td>Recurrent symptoms in a non-malignant and not imminently life/ vital organ/ limb threatening condition</td>
<td>Troublesome benign gall bladder disease/ symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult inguinal herniae</td>
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<tr>
<td></td>
<td></td>
<td>Intermittent claudication &lt;100m</td>
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<tr>
<td></td>
<td></td>
<td>Hyperparathyroidism</td>
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<tr>
<td></td>
<td>Other</td>
<td>Renal access for dialysis</td>
</tr>
<tr>
<td><strong>Routine</strong></td>
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<td></td>
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<tr>
<td></td>
<td>Benign cutaneous disease</td>
<td>Ingrown toenail</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pilonidal disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benign skin/ subcutaneous lumps e.g. lipoma, sebaceous cyst, unchanged naevi</td>
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<tr>
<td></td>
<td>Chronic benign disease</td>
<td>Irritable bowel syndrome</td>
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<tr>
<td></td>
<td></td>
<td>Chronic constipation</td>
</tr>
</tbody>
</table>
Exclusions:
The following conditions are of lowest clinical priority and therefore are highly unlikely to be assessed/ treated in this Department:

- Cultural circumcision
- Varicose veins with no skin changes or if asymptomatic
- Benign asymptomatic and/or static skin/subcutaneous lump
- Vasectomy for sterilisation
- Cosmetic surgery
GYNAECOLOGY/ObSTETRICS

FOCUS AND SCOPE:
Provides outpatient services for antenatal, gynaecology, sterilisation, colposcopy and fertility assessments.
Gynaecology, antenatal and colposcopy services are also provided at Horowhenua Hospital. Gynaecology and antenatal services are provided at Dannevirke.
Sterilisation assessment is for male and female sterilisation.

SPECIFIC REFERRAL INFORMATION:
• Refer to National Referral Guidelines for Gynaecology 2000
• Semen analysis
• Cycle tracking
• LUTEAL phase progesterone.

TESTS REQUIRED:
• All pregnant women should have a polycose screening and if positive a glucose tolerance test
• Bloods, smear history, swabs and scans
• Colposcopy – smear history and copies of smears
• Fertility – LHFSH thyroid function day three
  – Progesterone, day 21 x 2 results
• Referrals for infertility require a hormone profile and semen analysis
• Gynaecology – relevant investigation results.

OTHER INFORMATION:
Any woman with pre-existing IDDM or NIDDM should be referred 6 months before any planned pregnancy for pre-pregnancy education and control.
For urgent maternity enquiries phone Gynaecology/Obstetric Consultant On-call.

CONTACT:
Phone: (06) 356 9169 Ask for Consultant On-Call to be paged.
Fax: (06) 350 8402/350 8408

HOURS OF ATTENDANCE:
7.30 am – 4.00 pm.
# Gynaecology

National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for hospital specialists priorizing referrals from primary care.

1. **Immediate:** Acute admission to be arranged
2. **Urgent:** To be seen at next available clinic or within 2 weeks
3. **Semi-Urgent:** Within 4 weeks
4. **Routine:** Within 16 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or emailed (there may be local variation to this). The times to assessment may vary depending on unit and staffing of the hospital department.

## National Referral Guidelines: Gynaecology

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Urgent</td>
<td>• Diagnosed or suspected malignancy</td>
<td>• Highly abnormal cervical smear with cervical lesion</td>
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<tr>
<td></td>
<td></td>
<td>• Post menopausal bleeding</td>
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<td></td>
<td></td>
<td>• Gestational trophoblastic disease</td>
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<td></td>
<td></td>
<td>• Genital lesions or pelvic masses highly suspicious of cancer</td>
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<td></td>
<td>• Major functional disturbance</td>
<td>• Large masses causing symptoms</td>
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<td></td>
<td></td>
<td>• Heavy vaginal bleeding with severe anaemia</td>
</tr>
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<td></td>
<td>• Pain requiring narcotic or high levels of analgesia</td>
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</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>Pelvic masses with low risk of malignancy</td>
<td>• Ovarian cysts &gt; 5cms</td>
</tr>
<tr>
<td></td>
<td>• HGSI of cervix</td>
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<tr>
<td></td>
<td>• Vulval abnormalities</td>
<td>• Pruritus vulvae</td>
</tr>
<tr>
<td></td>
<td>• Anaemia</td>
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</tr>
<tr>
<td></td>
<td>• Moderate functional impairment</td>
<td>• Procidentia</td>
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<tr>
<td></td>
<td>• Chronic PID</td>
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<td></td>
<td>• Menorrhagia</td>
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<tr>
<td>4. Routine</td>
<td>• Gynaecological disorders with limited functional impairment</td>
<td>• Dysmenorrhoea</td>
</tr>
<tr>
<td></td>
<td>• Fertility</td>
<td>• Premenstrual symptoms</td>
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<tr>
<td></td>
<td>• Endocrine dysfunction</td>
<td>• Genital prolapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abnormal uterine bleeding</td>
</tr>
<tr>
<td></td>
<td>• Other non-urgent problems</td>
<td>• Amenorrhoea</td>
</tr>
<tr>
<td></td>
<td>• LCIS of cervix</td>
<td>• Hirsutism</td>
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<td></td>
<td>• PCO.</td>
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<tr>
<td></td>
<td></td>
<td>• Endometriosis</td>
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<tr>
<td></td>
<td></td>
<td>• Congenital abnormalities</td>
</tr>
</tbody>
</table>
National Access Criteria for Specialist Clinical Priority Assessment

General comments and directions

- These criteria do not apply to acute admissions, nor to surgery directly purchased by ACC.
- All sections of the form should be completed including particulars of diagnosis, procedure intended and the outcome of the assessment.
- Select one score only from each category from the options provided.
- The score should be calculated during the consultation, and the patient informed of their eligibility or otherwise for publicly funded treatment. This may occur during the first consultation or it may be a follow up consultation after investigations have assisted with establishing a diagnosis (e.g. CT scan).
- If there is a conflict between generally accepted clinical practice and the decision made by comparing a patient’s criteria score to the threshold, then generally accepted clinical practice should prevail. Do not adjust the total score but make comment in the box provided as to the reasons why the clinician considers that this patient is an exception. This must be clear so that hospital administrative staff are aware that the clinician has overridden the threshold score and will book the patient in for surgery. It is expected that the number of exceptions will be very small and those exceptions may be audited from time to time.

More than one procedure

Where two or more related procedures are contemplated at the same session (for example, under the same anaesthetic) then the score should relate to the most significant procedure. If the procedures are unrelated then a separate score should be determined for each procedure.

Staged procedures

A treatment procedure may be staged over several months or years. For the purposes of the priority access scoring a related series of treatments should be considered as one event. Repeat scoring is not required.

Diagnostic investigations or procedures

Unless there is a specific scoring category that is relevant (for example ‘suspicious of malignancy but unproven’), diagnostic investigations or diagnostic procedures should be scored as if the investigation will lead to the most likely unfavourable diagnosis. The patient will be scored again following diagnosis and before being booked for the definitive procedure.

SPECIFIC COMMENTS

Exclusions:

- These criteria only apply to elective and arranged admissions but not to acute admissions or ACC purchased surgery.
- These criteria exclude standard operative investigations or treatment for infertility unless the surgery is required to enhance physical health (e.g. ovarian cyst, endometriosis – see separate criteria undertaken at the secondary care level, but excludes tertiary infertility services (including tertiary-level infertility investigations) (separate criteria).
- Sterilisations are excluded (separate criteria).
- Planned terminations of pregnancy are excluded, as various requirements and processes are prescribed by the Contraception, Sterilisation and Abortion Act 1977.

Clinician judgement for scoring, not patient self-scoring

Scoring should be based on the considered view of the clinician taking into account the patient’s history, examination, results of investigations and the clinician’s experience in treating like patients. This is particularly with respect to scoring categories of ‘degree of pain’, ‘functional impairment’ and ‘social participation’. It is not appropriate for patients to be asked to complete these scores, as the differentiation between patients can only occur from the clinician’s experience of this patient compared to other patients in general, and so that the clinician can ensure that patients reported pain levels, etc. are consistent with the history and examination findings.

“Current Pathology” section

No pathology means conditions where surgery might be indicated although no pathological process is present. ‘Benign’ pathology and the other scoring options within this section mean abnormal function or structure. ‘Pregnancy’ includes CIN I - CIN III.

“Natural history” section

Window of opportunity: For some conditions there is an optimum time of treatment. If treatment is delayed the benefits of the procedure will substantially diminish or be lost altogether, or the potential for malignancy or another major complication is greatly increased. It is felt that such clinical situations should be afforded a higher priority.

“Degree of pain” section

(Refer ‘clinician judgement’ above.)

“Functional impairment” section

(Refer ‘clinician judgement’ above.)

Where relevant, this may include the impact on parents, guardians or caregivers of children and dependent patients.

“Social participation” section

This should be taken from the perspective of both the individual patient’s situation and ability as well as what is relevant to the patient’s age, gender, etc. Where consideration may be given to the patient’s situation, including, for example, the ability to work or carry out usual activities, live independently, undertake recreational activities, give care to dependents. For children, it is important that this should include the ability to participate in appropriate educational activities. (Refer ‘clinician judgement’ above.)

“Effectiveness of procedure/investigation” section

Diagnostic procedures/investigations are assumed to be fully effective. The effectiveness of therapeutic procedures should be based on the usual effectiveness of that procedure taking into account anything of direct relevance to the particular patient that would increase or reduce that effectiveness.
# Gynaecology

## National Clinical Priority Assessment Criteria (CPAC) for Treatment

### General Gynaecology

**Patient ID:** Complete patient details or place patient sticker here

<table>
<thead>
<tr>
<th>Nat. Hospital No.</th>
<th>Consultant:</th>
</tr>
</thead>
</table>

| Name: ____________________ | D.O.B. ___/___/___ |
| Address: ____________________ |

| Name of Assessor: |
| Date of Assessment: ___/___/___ |

### Diagnosis:

**Current pathology**
- Malignancy proven: 40
- Suspicious of malignancy, but unproven: 35
- Premalignancy: 30
- Benign: 10
- No pathology: 0

**Natural history of the potential/actual problem**
- Likely to progress to major complication/window of opportunity: 15
- Likely to continue to deteriorate: 10
- Likely to remain stable: 5
- Likely to improve in the short term: 0

**Degree of Pain**
- Severe (dominates life and regularly interferes with sleep): 10
- Moderate (persistent pain causing modification to aspects of daily living): 6
- Intermittent: 4
- Minimal or no pain: 0

**Functional impairment - disturbance in patient’s life including sexual function**
- Major disturbance: 15
- Moderate disturbance: 10
- Minor disturbance: 5
- No disturbance: 0

**Social participation**
- Immediately threatened: 10
- Threatened but not immediately: 6
- Not threatened but more difficult: 4
- Not threatened or difficult: 0

**Effectiveness of therapeutic procedure/diagnostic investigation**
- Diagnostic investigation or very effective therapeutic procedure: 10
- Moderately effective therapeutic procedure: 5
- Therapeutic procedure of low effectiveness: 0

### TOTAL: 

**COMMENTS:**
National Guidelines for using the National Sterilisation Clinical Priority Assessment Criteria (CPAC)

General comments and directions

- These sterilisation criteria apply to both female and male sterilisation. In the case of male sterilisation the female partner's age, user contraception and medical history are to be considered.

- All sections of the form should be completed including particulars of diagnosis, procedure intended and the outcome of the assessment.

- Select one score only from each category from the options provided.

- The score should be calculated during the consultation, and the patient informed of their eligibility or otherwise for publicly funded treatment.

- If there is a conflict between generally accepted clinical practice and the decision made by comparing a patient's criteria score to the threshold, then generally accepted clinical practice should prevail. Do not adjust the total score but make comment in the box provided as to the reasons why the clinician considers that this patient is an exception. This must be clear so that CHE administrative staff are aware that the clinician has overridden the threshold score and will book the patient in for surgery. It is expected that the number of exceptions will be very small and these exceptions may be audited from time to time.

More than one procedure

Where two or more related procedures are contemplated at the same session (for example, under the same anaesthetic) then the score should relate to the most significant procedure. If the procedures are unrelated then a separate score should be determined for each procedure.

"User contraception" section

User contraception difficulty is irrespective of cause and may, for example, relate to:

- either the woman or her partner
- inability to use other forms of contraception
- unsuitability of other forms of contraception
- adverse reactions or allergies
# National Clinical Priority Assessment Criteria (CPAC) Sterilisation Procedures

**Patient ID:** Complete patient details or place patient sticker here

<table>
<thead>
<tr>
<th>Nat. Hospital No.:</th>
<th>Consultant:</th>
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</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>D.O.B.</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
</tbody>
</table>

| Name of Assessor: | | Date of Assessment: ___/___/___ |
|-------------------|-------------|

| **Age of female** | | **COMMENTS** |
|-------------------|-------------|
| 30 years or younger | 5 | |
| 31-35 years | 10 | |
| 36 years or older | 15 | |

| **Number of live children** | | **COMMENTS** |
|-----------------------------|-------------|
| 0 | 0 | |
| 1-3 | 5 | |
| More than 3 | 10 | |

| **Unplanned pregnancies** | | **COMMENTS** |
|---------------------------|-------------|
| Nil | 0 | |
| 1 | 10 | |
| 2 | 15 | |
| 3 or more | 20 | |

| **User contraception** | | **COMMENTS** |
|------------------------|-------------|
| No contraception difficulty | 0 | |
| User contraception difficult (irrespective of cause) | 25 | |

| **Medical History: Health risk impact due to potential pregnancy** | | **COMMENTS** |
|-------------------------------------------------------------------|-------------|
| No identified health risk | 0 | |
| Health problems that increase health risk during pregnancy | | |
| (mild) | 10 | |
| (moderate) | 20 | |
| (severe) | 30 | |

**TOTAL**
**D1 Initial Assessment**

<table>
<thead>
<tr>
<th>(1) Ovulation Defects</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>From history, including</td>
<td></td>
</tr>
<tr>
<td>• a plasma progesterone timed for 5-9 days before the next expected period. If cycle is long to be repeated at weekly intervals until next period</td>
<td></td>
</tr>
<tr>
<td>• plasma FSH, LH, prolactin, thyroid function if the cycle is prolonged and/or irregular. FSH (day 2-5 cycle) for older women (is measure of biological age of ovary).</td>
<td></td>
</tr>
<tr>
<td>amenorrhoea - any cause</td>
<td>6</td>
</tr>
<tr>
<td>oligomenorrhoea from any cause / luteal defect</td>
<td>3</td>
</tr>
<tr>
<td>anovulation with normal menstrual cycle</td>
<td></td>
</tr>
<tr>
<td>intermittent anovular cycles</td>
<td>1</td>
</tr>
<tr>
<td>no ovulation defect</td>
<td>0</td>
</tr>
</tbody>
</table>

**Score 1**

<table>
<thead>
<tr>
<th>(2) Semen Defects</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semen sample collected after 2-3 days abstinence. To be repeated in 6-8 weeks if abnormal.</td>
<td></td>
</tr>
<tr>
<td>The measurement of antisperm antibodies, post coital test or other sperm function tests are not essential for this category, but may be included as indicated</td>
<td></td>
</tr>
<tr>
<td>&lt;1 million motile sperm/ml / severe ejaculatory dysfunction / severe sperm antibodies</td>
<td>6</td>
</tr>
<tr>
<td>1-5 million motile sperm/ml / moderate antibodies / repeat negative PCT or sperm function abnormality</td>
<td>3</td>
</tr>
<tr>
<td>5-10 million motile sperm/ml</td>
<td>2</td>
</tr>
<tr>
<td>Any other semen defect</td>
<td>1</td>
</tr>
<tr>
<td>No semen defect</td>
<td>0</td>
</tr>
</tbody>
</table>

**Score 2**

<table>
<thead>
<tr>
<th>(3) Endometriosis</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>The American Fertility Society Classification (American Society for Reproductive Medicine 1997). This requires direct visualization by laparoscopy. Surgical treatment at the time of diagnosis will be at the discretion of the gynaecologist conducting the procedure, depending on the common practice of the clinic.</td>
<td></td>
</tr>
<tr>
<td>stage I AF5 classification</td>
<td>6</td>
</tr>
<tr>
<td>stage III AF5 classification</td>
<td>3</td>
</tr>
<tr>
<td>stage II AF5 classification</td>
<td></td>
</tr>
<tr>
<td>stage I AF5 classification</td>
<td></td>
</tr>
<tr>
<td>No endometriosis</td>
<td>0</td>
</tr>
</tbody>
</table>

**Score 3**
### (4) Other Tubo-peritoneal Disease

<table>
<thead>
<tr>
<th>Categories</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximal or distal (complete or partial) occlusion on best-side / severe encapsulating tubal or ovarian adhesions on best-side / missing tubes / or unsuccessful proximal or distal surgery after 12 months</td>
<td>6</td>
</tr>
<tr>
<td>Moderate encapsulating tubal or ovarian adhesions on best-side adnexa / unsuccessful surgery after 6 months</td>
<td>3</td>
</tr>
<tr>
<td>Tubal polyps / mild encapsulating adhesions on best-side or / normal tube on best-side with tubal occlusion on the other-side or uterine adhesions</td>
<td>2</td>
</tr>
<tr>
<td>Minimal tubal or ovarian adhesions on best-side adnexa</td>
<td>1</td>
</tr>
<tr>
<td>No tubo-peritoneal pathology</td>
<td>0</td>
</tr>
</tbody>
</table>

**SCORE 4**

### (5) Other Factors

<table>
<thead>
<tr>
<th>Categories</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>6</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
</tr>
<tr>
<td>Minimal</td>
<td>1</td>
</tr>
<tr>
<td>Absent</td>
<td>0</td>
</tr>
</tbody>
</table>

**SCORE 5**

### D⁰  No diagnosis abnormality identified, i.e. unexplained infertility

### (6) Unexplained Infertility

<table>
<thead>
<tr>
<th>Categories</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained infertility ≥ 5 years</td>
<td>6</td>
</tr>
<tr>
<td>Unexplained infertility ≥ 4 &lt; 5 years</td>
<td>3</td>
</tr>
<tr>
<td>Unexplained infertility ≥ 3 years &lt; 4 years</td>
<td>2</td>
</tr>
<tr>
<td>Unexplained infertility &lt; 3 years</td>
<td>1</td>
</tr>
</tbody>
</table>

**SCORE 6**

### Final Score for Diagnosis

Add scores 1, 2, 3, 4, 5 = Score D¹⁺²

Score 6 = Score D⁰

**Diagnostic score (D) is D¹⁺² or D⁰ which ever is the highest**
# Gynaecology

National Clinical Assessment Criteria (CPAC) for Treatment of Infertility

**Patient ID:** Complete patient details or place patient sticker here

<table>
<thead>
<tr>
<th>Nat. Hospital No.</th>
<th>Consultant:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>D.O.B.</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Assessor:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Assessment:</th>
<th></th>
</tr>
</thead>
</table>

## Calculation of priority criteria points for publicly-funded infertility treatment

<table>
<thead>
<tr>
<th>Criteria symbol</th>
<th>Points awarded</th>
<th>Criteria and their categories</th>
<th>Points available</th>
</tr>
</thead>
<tbody>
<tr>
<td>O1</td>
<td></td>
<td>Chance of pregnancy without treatment</td>
<td>≤ 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6-20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>21-50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt;50%</td>
</tr>
<tr>
<td>O2</td>
<td></td>
<td>Woman's age</td>
<td>≤ 37 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>38-45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>46-51</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>52+</td>
</tr>
<tr>
<td>O3</td>
<td></td>
<td>Basal FSH, day 2-5 cycle, with respect to reference range</td>
<td>always within</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>sometimes above</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>mostly/always above</td>
</tr>
<tr>
<td>O4</td>
<td></td>
<td>Woman's smoking</td>
<td>non smoker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>smoker</td>
</tr>
</tbody>
</table>

Multiply O1 \times O2 \times O3 \times O4 = OC (points from objective criteria)

\[
OC = \frac{OC}{10000} = Revised OC (ROC)
\]

<table>
<thead>
<tr>
<th>S1</th>
<th>Duration of infertility</th>
<th>Points available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤ 1 year</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>1-3 years</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>≥ 5 years</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S2</th>
<th>Number of children</th>
<th>Points available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>1 by current relationship</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>&gt; 1 by current relationship</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>&gt; 1 child by prev relationship</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S3</th>
<th>Sterilisation reference range</th>
<th>Points available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>neither partner sterilised</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>death of child &amp; one partner sterilised</td>
<td>20</td>
</tr>
</tbody>
</table>

Sum S1 + S2 + S3 = SC (points from social criteria)

Multiply ROC \times SC = Priority Score (PS)
National Access Criteria for Specialist Clinical Priority Assessment

General comments and directions

- These criteria do not apply to acute admissions, nor to surgery directly purchased by ACC.
- All sections of the form should be completed including particulars of diagnosis, procedure intended and the outcome of the assessment.
- Select one score only from each category from the options provided.
- The score should be calculated during the consultation and the patient informed of their eligibility or otherwise for publicly funded treatment. This may occur during the first consultation or it may be in a follow up consultation after investigations have assisted with establishing diagnosis (e.g. CT scans).
- If there is a conflict between generally accepted clinical practice and the decision made by comparing a patient's criteria score to the threshold, then generally accepted clinical practice should prevail. Do not adjust the total score but make comment in the box provided as to the reasons why the clinician considers that this patient is an exception. This must be clear so that hospital administration staff are aware that the clinician has over-ridden the threshold score and will book the patient in for surgery. It is expected that the number of exceptions will be very small and those exceptions may be audited from time to time.

More than one procedure

Where two or more related procedures are contemplated at the same session (for example, under the same anaesthetic) then the score should reflect the most significant procedure. If the procedures are unrelated then a separate score should be determined for each procedure.

Staged procedures

A treatment procedure may be staged over several months or years. For the purposes of the priority access scoring a related series of treatments should be considered as one event. Repeat scoring is not required.

Diagnostic investigations or procedures

Unless there is a specific scoring category that is relevant (for example, suspicious of malignancy but unproven), diagnostic investigations or diagnostic procedures should be scored as if the investigation will lead to the most likely unfavourable diagnosis. The patient will be scored again following diagnosis and before being booked for the definitive procedure.

SPECIFIC COMMENTS

Exclusions:

- These criteria only apply to elective and arranged admissions but not to acute admissions nor ACC purchased surgery.
- These criteria exclude standard operative investigations or treatment for infertility unless the surgery is required to enhance physical health (e.g. ovarian cysts, endometriosis – see separate criteria undertaken at the secondary care level but excludes tertiary infertility services (including tertiary level infertility investigations) (separate criteria).
- Sterilisations are excluded (separate criteria).
- Planned terminations of pregnancy are excluded, as various requirements and processes are prescribed by the Contraception, Sterilisation and Abortion Act 1977.

Clinician judgement for scoring, not patient self-scoring

Scoring should be based on the considered view of the clinician taking into account the patient's history, examination, results of investigations and the clinician's experience in treating like patients. This is particularly with respect to the scoring categories of 'degree of pain', 'functional impairment' and 'social participation'. It is not appropriate for patients to be asked to complete these scores, as the differentiation between patients will only occur from the clinician's experience of this patient compared to other patients in general, and so that the clinician can ensure that patient reported pain levels, etc. are consistent with the history and examination findings.

"Current Pathology" section

No pathology means conditions where surgery might be indicated although no pathological process is present. 'Benign' pathology and the other scoring options within this section mean abnormal function or structure. 'Premalignancy' includes CIN 1 - CIN 3.

"Natural history" section

'Window of opportunity': For some conditions there is an optimum time of treatment. If treatment is delayed the benefits of the procedure will substantially diminish or be lost altogether, or the potential for malignancy or another major complication is greatly increased. It is felt that such clinical situations should be afforded a higher priority.

"Degree of pain" section

(Refer 'clinician judgement' above.)

"Functional impairment" section

(Refer 'clinician judgement' above.)

Where relevant, this may include the impact on parents, guardians or caregivers of children and dependent patients.

"Social participation" section

This should be taken from the perspective of both the individual patient's situation and ability as well as what is relevant to the patient's age, gender, etc. Wide consideration may be given to the patient's situation, including, for example, the ability to work or carry out usual activities like independently, undertake recreational activities, give care to dependents. For children, it is important that this should include the ability to participate in appropriate educational activities. (Refer 'clinician judgement' above.)

"Effectiveness of procedure/investigation" section

Diagnostic procedures/investigations are assumed to be fully effective. The effectiveness of therapeutic procedures should be based on the usual effectiveness of that procedure taking into account anything of direct relevance to the particular patient that would increase or reduce that effectiveness.
# HAEMATOLOGY

## National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Immediate**
   - seen / treatment within 24 hours
   - Neutropenic sepsis
   - Newly diagnosed acute leukaemia / lymphoma
   - Haemophilia
   - ITP with Platelets <20\*
     + bleeding
   - Autoimmune haemolytic anaemia
   - Aplastic anaemia
   - Hyperviscosity
     - Waldenstrom’s macroglobulinaemia
     - CML with a very high WBC count
     - Polycythaemia with thrombovascular symptoms
   - Cord compression
   - Acute renal failure
   - Hypercalcaemia
   - Tumour lysis syndrome
   - Multiple myeloma
   - High grade Non-Hodgkins lymphoma
   - Burkitts lymphoma

2. **Urgent**
   - Bone Pain
   - Risk of bone fracture
   - Renal impairment
   - Moderate risk of infection
   - Neutropenia <1 x 10⁹L
   - Moderate/severe Thrombocytopenia <50 x10⁹L
   - New Haemophilia
   - Progressiv symptomatic anaemia
   - Some Myelodysplasia
   - Some Autoimmune Haemolytic Anaemia
   - Chronic Myeloid Leukaemia
   - Severe symptomatic leucocytosis
   - Some Polycythaemia Rubra Vera (PRV)
   - Some Waldenstrom’s Macroglobulinaemia
   - Lymphopenia / lymphocytosis
   - Stage C Chronic Lymphocytic Leukaemia

---

Version 1 Haematology Referral Guidelines and Priorisation Criteria  - Date: 3/11/2000  - Authorised: Elective Services, HFA
HOME HELP

FOCUS AND SCOPE:
 Temporary incapacity through illness and/or medical intervention.
 Unable to perform usual household tasks.
 Have no immediate family or other occupants of the house able to help.

SPECIFIC REFERRAL INFORMATION:
 Please refer on form available from Supportlinks.

TESTS REQUIRED:
 Nil.

OTHER INFORMATION:
 Nil.

CONTACT:
 Phone: (06) 357 8050  Postal: Supportlinks
 Fax: (06) 353 5070  P O Box 188
 Email: supportlinks@midcentral.co.nz  Palmerston North

HOURS OF ATTENDANCE:
 8.00 am – 5.30 pm, Monday to Friday.
HOSPITAL IN THE HOME (HITH)

FOCUS AND SCOPE:

A service that delivers specialist level medical treatment and specialised nursing care for patients suffering from an acute illness or an acute exacerbation of a chronic illness and who prefer to be cared for outside of the hospital.

There is a set of entry criteria that must be met prior to accepting a patient into this service (see HITH referral form).

For further information regarding this service, see District Nursing Service in directory.
FOCUS AND SCOPE:
Adult patients with problems that are or may be caused by infections including pyrexia of unknown origin, infections complicating surgical procedures, Hepatitis B, unusual organisms obtained on culture, recurrent cellulitis or boils, and patients necessitating intravenous antibiotics for admission to Hospital in the Home Services.

SPECIFIC REFERRAL INFORMATION:
General description of current problem(s), background, medical conditions, and medication, especially previous antibiotics prescribed.

TESTS REQUIRED:
Nil specific. Please include results of all previous investigations especially if done by other DHB’s.

OTHER INFORMATION:
Please refer the following patients to these special clinics:-
- HIV patients to the Sexual Health Centre, unless the patient specifically asked to be seen at the Infectious Diseases Clinic
- Hepatitis C patients to Gastroenterology
- Chronic Fatigue Syndrome of unknown cause to General Medicine
- Hepatitis B patients to the Infectious Diseases Clinic
- Post Meningitis/encephalitis patients to Neurology
- Pulmonary tuberculosis patients to Respiratory Medicine
- Extra pulmonary tuberculosis (e.g. lymphnodes with a normal chest x-ray) to the Infectious Diseases Clinic
- Travel medicine (vaccines, prophylaxis) to Dr Jane Parker in Microbiology
- Outbreaks of communicable diseases (e.g. diarrhoea and vomiting) in the community or nursing homes to Public Health

CONTACT:
Phone: (06) 350 8610
Postal: Ambulatory Care Centre
Palmerston North Hospital
Private Bag 11036
Palmerston North
IV THERAPY

FOCUS AND SCOPE:
The service advises and consults on care and management of IV Therapy and other related Therapies, so patients accessing MidCentral Health facilities receive skilled and competent care. The IV Therapy service provides education based on research and best based practice for nursing and medical personnel, and patients.

SPECIFIC REFERRAL INFORMATION:
Any patient with a vascular access device can be referred to the IV Therapy team for consultation.

TESTS REQUIRED:
Chest X-ray following insertion of a Central Venous Access Device.

REFERRAL CRITERIA:
- Care and management of vascular access devices (VADs) including troubleshooting and subcutaneous therapy.
- Appropriate selection of vascular access devices.
- Intravenous nutritional support – providing education on rate tampering, and instigating home TPN.
- Patient education
  - VADs
  - preparation of medication
  - self-administration of medicines

All referrals to be completed on the Community Health Referral form. Please indicate on the form if the patient is receiving IV Therapy in the hospital or community.

OTHER INFORMATION:
Include in the referral:
- Type of vascular access device and dwell time
- Type and duration of treatment

CONTACT:
IV Assessors are available in wards/departments for advice and assistance.
Clinical Nurse Specialist
Phone: (06) 350-8206
Page: 060

Infusion Nurse Educator
Phone: (06) 350-8209
Page: 060

HOURS OF ATTENDANCE:
8:00 AM to 4:00 PM Monday through Friday
FOCUS AND SCOPE:

- Provides consultancy advice and support to MidCentral Health on the provision of services appropriate to meet Māori health needs.
- Provides accommodation for whanau/family from outside the MidCentral DHB region.

SPECIFIC REFERRAL INFORMATION:

Identifying:
1. Cultural safety issues/barriers to health services.
2. Clinical information e.g. current health problems etc.
3. If Iwi Health Provider is involved in client care, this information at time of referral could speed up response time.

REFERRAL CRITERIA:

OTHER INFORMATION:

CONTACT:

Phone: (06) 350-8210
Fax: (06) 350-8158
Email: maorihu@midcentral.co.nz

HOURS OF ATTENDANCE:

8:00 AM – 4:30 PM Monday through Friday
Contact outside these hours is via the After hours Co-ordinator
**MEALS ON WHEELS**

**FOCUS AND SCOPE:**

People recently discharged from secondary health services who require short term assistance with meals. Older people and people with physical disabilities requiring ongoing assistance with meals. Clients of primary health care services requiring short term assistance with meals.

**SPECIFIC REFERRAL INFORMATION:**

Please refer using referral form available from Supportlinks.

**TESTS REQUIRED:**

Nil.

**OTHER INFORMATION:**

Nil.

**CONTACT:**

Phone: (06) 357 8050
Fax: (06) 353 5070
Email: supportlinks@midcentral.co.nz

Postal: Supportlinks
P O Box 188
Palmerston North

**HOURS OF ATTENDANCE:**

8.00 am – 5.30 pm, Monday to Friday.
MENTAL HEALTH SERVICES

FOCUS AND SCOPE:

Mental Health Services comprise General Adult Mental Health, including inpatient and outpatient services; plus specialist services consisting of Maori Mental Health, Child Adolescent and Family Mental Health and Alcohol and Drug Services. All services are provided to people in Palmerston North, Manawatu, Tararua and Horowhenua. Inpatient services for intensive, acute and sub-acute episodes are provided in Palmerston North. The primary focus of Mental Health Services is the provision of specialist services for persons who have moderate to severe mental ill health and require assessment, treatment and care.

SPECIFIC REFERRAL INFORMATION:

Referrals should be addressed to respective teams rather than individual consultants or practitioners.

- If the person identifies as Maori (all ages) they have the choice whether to be referred to Oranga Hinengaro, (Specialist Maori Mental Health Team).
- If Alcohol and Drug use and/or pathological gambling are the main factors in the person’s presentation, refer to the Alcohol and Drug Service.
- If non-Maori and under 18 years of age, refer to the specialist Child, Adolescent and Family Service.
- If the person is over 65 years with an age related illness, they are to be referred to Services for the Elderly.
- In the case of crisis or emergency requiring an immediate response, refer direct to the Crisis Assessment Team.

For referral of an adult, an Adult Mental Health Services form is available or your letter should include the following:

- Reason for referral
- Current treatment/management plan
- Risk factors including; suicide intent, threats to others, aggression/violence, forensic history etc
- Duration and history of problem
- Maori/whanau related issues
- Medical (non psychiatric) conditions and history including recent examinations and outcome
- Family and personal psychiatric history
- Alcohol and drug use. Other services involved (MASH, CYFs, Police, Special Education etc)
- Legal status of the patient
- Any other relevant information.

TESTS REQUIRED:

- Full blood work up if relevant.
- If on psychiatric medications, monitoring that blood levels are up to date.
OTHER INFORMATION:
Not all referrals will be seen by a Psychiatrist. They are usually seen in the first instance by a Mental Health Professional from the multidisciplinary team and assessed. That assessment is discussed by the treatment team, which includes the Consultant Psychiatrist as part of treatment and discharge planning. Also refer to information on Child, Adolescent and Family Mental Health in this folder.

CONTACT:
Relevant Specialist Team
Mental Health Services
Palmerston North Hospital
Private Bag 11036
Palmerston North
NEPHROLOGY (RENA L MEDICINE)

FOCUS AND SCOPE:
Patients of any age may be referred. Indications for referral include, but are not limited to: renal failure, proteinuria including nephrotic syndrome, haematuria, hypertension, urinary tract infections, electrolyte abnormalities, acid/base abnormalities and polyuria or urinary frequency,

SPECIFIC REFERRAL INFORMATION:
Results of relevant tests already performed.
Current medications.

TESTS REQUIRED:
All new patients:
Blood – renal profile
– full blood count
– other tests as indicated.
Urine – 24 hour urinary protein, creatinine and sodium if indicated.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8610
Postal: Ambulatory Care Centre
Palmerston North Hospital
Private Bag 11036
Palmerston North
NEUROLOGY

FOCUS AND SCOPE:
Assessment and investigation of patients presenting with neurological type symptoms or neurological signs. Advice is also given on the treatment and management of patients with neurological disorders and diseases. This service focuses primarily on adult neurological problems, however, referrals from Specialist Paediatricians are welcome.

SPECIFIC REFERRAL INFORMATION:
Detailed history.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
EEG do not require specialist approval
EMG require specialist approval.

CONTACT:
Phone: (06) 350 8610  Postal: Ambulatory Care Centre
                           Palmerston North Hospital
                           Private Bag 11036
                           Palmerston North
# Neurology

## National Referral Guidelines

### Specific Neurology Referral Letter Guidelines

Referrals should include the reason for referral:
- Evolution? Relapsing, Deteriorating
- Relevant Physical Signs
- Has the patient been seen at this clinic before?
  - When?
  - By whom

## National Access Criteria for First Specialist Assessment (ACA)

**Category Definitions**: These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. Immediate - requires admission to an acute facility as soon as possible
2. Urgent - within 7 weeks
3. Semi-Urgent - within 8 weeks
4. Routine - within 24 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

Access criteria that determine prioritisation primarily on the referral diagnosis have their limitations and this is acknowledged. For those referrals in which the referring doctor has not been able to make a confident diagnosis it may be difficult, or impossible, to apply those ACA criteria. It is therefore stressed that these are guidelines only and that clinical judgement must be applied in all cases in which they are used.

## National Referral Guidelines: Neurology

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>Sudden onset life threatening conditions</td>
<td>Subarachnoid Haemorrhage</td>
</tr>
<tr>
<td></td>
<td>Loss of consciousness/syptoms of raised intracranial pressure</td>
<td>Space occupying lesions, encephalitis</td>
</tr>
<tr>
<td></td>
<td>Rapidly evolving paralysis (any cause) with or without respiratory difficulty</td>
<td>Spinal cord lesions, myasthenia gravis, Guillain Barre syndrome</td>
</tr>
<tr>
<td></td>
<td>Progressive paralysis with recent loss or disturbance of sphincter function</td>
<td>Spinal cord compression/cauda equina syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meningitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>Rapidly evolving or episodic neurological dysfunction with a potential for serious neurological impairment. (usually over days to weeks)</td>
<td>Paralysis due to any cause</td>
</tr>
<tr>
<td></td>
<td>Signs or suspicion of raised intracranial pressure but normal function</td>
<td>Serial TIAs</td>
</tr>
<tr>
<td></td>
<td>Neurological symptoms during pregnancy</td>
<td>Deteriorating seizure control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Papilloedema/local neurological disturbance including cognitive</td>
</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>Progressive loss of neurological function (slower rate than 2)</td>
<td>1st seizure</td>
</tr>
<tr>
<td></td>
<td>Poorly controlled neurological pain</td>
<td>Symptoms suggestive of Multiple sclerosis, neuropathy, myopathy, motor neurone disease etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trigeminal neuralgia</td>
</tr>
<tr>
<td>Category</td>
<td>Criteria</td>
<td>Examples (not an exhaustive list)</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>4. Routine</td>
<td>• Chronic neurodegenerative disorders acquired or inherited. (Slow rate of progression or long history &gt; years) • Diagnostic or management issues</td>
<td>• Dementias • Extrapyramidal syndrome i.e. Parkinson's Disease • Ataxias • Tremor • Muscular dystrophies and myopathies and neuropathies • Previously diagnosed conditions such as migraine, second opinion and reports</td>
</tr>
</tbody>
</table>

**Notes:**
- *Paediatric Neurology* is normally dealt with by Paediatricians with referral to paediatric neurologists as appropriate.
- *Patients with conditions requiring immediate treatment*, such as suspected bacterial meningitis, subarachnoid haemorrhage, encephalitis, stupor and coma, status epilepticus, rapid development of paraplegia or quadriplegia, sudden severe headache, disabling stroke, myasthenia crisis should be referred to an acute facility for admission.
- *Patient social and economic circumstances may, in some instances, influence their categorisation.*
NUCLEAR MEDICINE

FOCUS AND SCOPE:

- Diagnostic imaging with radio-isotopes.
- Diagnostic function tests such as the test for GFR.
- Radio-iodine therapy for hyperthyroidism, and therapy with other unsealed radioisotopes.

SPECIFIC REFERRAL INFORMATION:

- Test requests – we require a “hard copy” request even before booking urgent scans. Transmission by facsimile is welcome.
- Patient and referring doctor details – we require full patient identification and contact information. If the referring doctor wishes to receive the report, we also require clear legible identification of who you are and what address the report should go to.
- Clinical information – complete relevant clinical information will enable us to give your patient the most appropriate priority and perform the most appropriate examination. Dr Smidt is happy to discuss what may be the most appropriate investigation for a particular clinical indication.
- Specific imaging guidelines – A booklet “Making the Best Use of a Department of Clinical Radiology and Nuclear Medicine” is available from the Radiology Department. This gives the suggested imaging procedures for a variety of clinical problems.
- Appointments – we generally work to a tight schedule and it is important that patients arrive on time and allow additional time for parking.

SPECIAL REQUIREMENTS:

- Patient preparation – most scans require no special preparation. Patients are given specific instructions where special preparations are required or where there may be a wait between phases of a study.
- Thyroid isotope scans – it is generally a waste of time attempting a thyroid scintigram in a patient taking replacement thyroxine or in someone who takes Kelp or similar iodine supplements, or Amiodarone.
- Captopril or Losartan renograms for renovascular hypertension. Regular ACE inhibitors or Angiotension-II receptor antagonists should be stopped one week before the renogram, so the patient should be weaned onto a non-ACEI hypertensive in preparation for the scan.
- Coronary perfusion scans. The patient is required to not take any beta blocker or long-acting nitrate on the morning of the scans.

TESTS REQUIRED:

Nil.
OTHER INFORMATION:

- Results are normally dispatched no later than 24 hours, and usually within 12 hours of completion of the test or scan. On request (and with fax number supplied) reports may be faxed. (Reports are also sent to Healthlink e-mail addresses.)
- Please do not tell the patient that we will tell them the result. Technologists are instructed not to give their opinions, nor do we normally give results directly to patients. This is to allow the patient’s medical advisor to discuss the result with the patient and to interpret it in the light of other clinical information.

CONTACT:

Enquiries: (06) 350 8450
Nuclear Medicine Physician: (06) 350 8454
Facsimile: (06) 350 8453
FOCUS AND SCOPE:

The Nurse Case Co-ordinator (NCC) has a case load of clients referred by the MDT and co-ordinates services/resources across the continuum for identified complex medical patients. Focus is directed toward the whole episode of care for the patient rather than disease focus.

SPECIFIC REFERRAL INFORMATION:

Referral Follow-up:
The NCC will assess the patient against the criteria this will be documented in the clinical notes with any recommendations as appropriate. If the patient meets criteria and consents to case management this will also be documented in the clinical notes and co-ordination of care will commence from that initial assessment.

REFERRAL CRITERIA:

Medical patients who are multiple service/agency users with one or more of the following:
- Highly complex / chronic / co-morbidities.
- Multiple psycho-social problems (associated with complex socio-economic issues).
- Frequent re-admissions.
- Have previously been Case Co-ordinated.

OTHER INFORMATION:
FOCUS AND SCOPE:

Occupational Therapy offers rehabilitation, assessment and treatment to enable clients to maximise their independence in daily tasks. Services include:

- Cognitive/perceptual, physical and functional assessment
- Retraining of self care tasks
- Adapting the home environment to increase safety and independence – this may include applying for funding for equipment or housing modifications
- Education, e.g. Energy conservation, joint protection techniques, stress management
- Hand therapy and Scar management

SPECIFIC REFERRAL INFORMATION:

Non Accident Related Referrals:

- Reason for referral
- Diagnosis
- Prognosis
- Past medical history
- Contact person with phone number
- Present support
- Presenting features – cognitive and physical
- Other health professional referrals/involvement
- Has referral been discussed with client?

Accident Related Referrals (all the above PLUS):

- Date of injury
- Read Code
- Case Manager (if known)
- Any previous treatments for the same injury

TESTS REQUIRED:

Nil.

OTHER INFORMATION:

Refer above. All accident related cases must go through the appropriate insurance company, with date and site of injury.

CONTACT:

Phone: (06) 350 8182 or 0800 741 222
Fax: (06) 350 8122
Email: CentralReferral@midcentral.co.nz

Postal: Central Referral Management
Rehabilitation Service
Palmerston North Hospital
Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:

8.00 am – 5.00 pm, Monday to Friday.
FOCUS AND SCOPE:
To see patients with morbidity of the eyes, orbits and visual system and to provide medical and or surgical management for these.

SPECIFIC REFERRAL INFORMATION:
Refer to National Referral Guidelines for Ophthalmology.
1) An accurate description of the problem as the patient perceives it.
2) A concise summary of the patient’s problem, for example:
   a) visual acuity
   b) eye involved
   c) any treatment in progress
   d) other conditions and treatments
3) If referring patients from other HHS, please supply all relevant information.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Family history
Past ocular history
Referrals for Diabetic Photoscreening (DPS) will only be accepted on DPS referral forms available from this service.

CONTACT:
Phone: (06) 350 8610 Postal: Ambulatory Care Centre
Postal: Palmerston North Hospital
Private Bag 11036
Palmerston North
<table>
<thead>
<tr>
<th>Disease or Diagnosis</th>
<th>Category</th>
<th>Score Range</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute glaucoma</td>
<td>1</td>
<td>91-100</td>
<td></td>
</tr>
<tr>
<td>Chronic glaucoma with high risk of visual loss</td>
<td>2</td>
<td>71-90</td>
<td></td>
</tr>
<tr>
<td>Neovascular glaucoma</td>
<td>2</td>
<td>71-90</td>
<td></td>
</tr>
<tr>
<td>Glaucoma with pain</td>
<td>2</td>
<td>71-90</td>
<td></td>
</tr>
<tr>
<td>Chronic glaucoma with low risk of visual loss</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens induced glaucoma</td>
<td>2</td>
<td>71-90</td>
<td></td>
</tr>
<tr>
<td>Cataract extraction required in order to treat posterior segment, disease e.g. Diabetic retinopathy</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>All other cataracts see separate scoring system</td>
<td>4 or 5</td>
<td>0-50</td>
<td></td>
</tr>
<tr>
<td>Corneal Disease Requiring Keratoplasty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score as for cataract but add 20 points for long visual recovery</td>
<td>4</td>
<td>3-70</td>
<td></td>
</tr>
<tr>
<td>Squint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of amblyopia or loss of BSV</td>
<td>3</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Causing diplopia</td>
<td>3</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Cosmetic with impact on psychological development</td>
<td>4</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Cosmetic &gt;20 prism dioptres with psychological impact</td>
<td>4</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Cosmetic &gt;20 prism dioptres</td>
<td>4</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Cosmetic &lt;20 prism dioptres</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Ptosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric threatening vision</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Adult affecting vision</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
<tr>
<td>Cosmetic severe</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>Epiphora</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Adult - troublesome</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
<tr>
<td>Ectropion/Entropion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entropion</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Ectropion with corneal pathology</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Ectropion without corneal pathology</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
<tr>
<td>Pterygium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threatening vision</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
<tr>
<td>Non-threating</td>
<td>5</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>Staged Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EVA, radiation plaque, skin flaps, strabismus reoperations, vitrectomy surgery, etc</td>
<td>6</td>
<td>Staged</td>
<td></td>
</tr>
<tr>
<td>Refractive Eye Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amblyogenic refractive errors</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Low vision aids</td>
<td>4</td>
<td>21-50</td>
<td></td>
</tr>
</tbody>
</table>

Notes: If the patient requires more than one procedure the score should relate to the most significant procedure. If there is a conflict between the patient's criteria score and generally accepted clinical practice then the latter should prevail.
# Ophthalmology

**National Clinical Priority Assessment Criteria (CPAC)**

<table>
<thead>
<tr>
<th>Patient ID: Complete patient details or place patient sticker here</th>
<th>Nat. Hospital No.:</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>D.O.B. ___ / ___ / ___</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of Assessor:**

**Date of Assessment:** ___ / ___ / ___

**Diagnosis:**

**Procedure:**

**Category Definitions:**
1. Immediate (91 - 100 points) - within 24 hours
2. Urgent (71 - 90 points) - within 4 weeks
3. Semi-Urgent (51 - 70 points) - within 12 weeks
4. Routine (21 - 50 points) - within 6 months
5. Deferred (-20 points) - deferred
6. Staged/Planned - management to achieve optimal outcome

## National Referral Guidelines: Ophthalmology

<table>
<thead>
<tr>
<th>Disease or Diagnosis</th>
<th>Category</th>
<th>Score Range</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ocular Trauma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute trauma - priority determined case by case</td>
<td>1 or 2</td>
<td>71-100</td>
<td></td>
</tr>
<tr>
<td>Blowout fracture</td>
<td>2</td>
<td>71.90</td>
<td></td>
</tr>
<tr>
<td><strong>Infections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endophthalmitis - usually following penetrating trauma or surgery</td>
<td>1</td>
<td>91-100</td>
<td></td>
</tr>
<tr>
<td>Acute keratitis</td>
<td>1</td>
<td>91-100</td>
<td></td>
</tr>
<tr>
<td>Orbital cellulitis</td>
<td>1</td>
<td>91-100</td>
<td></td>
</tr>
<tr>
<td>Acute dacryocystitis</td>
<td>1</td>
<td>91-100</td>
<td></td>
</tr>
<tr>
<td>Chronic dacryocystitis</td>
<td>4</td>
<td>21.50</td>
<td></td>
</tr>
<tr>
<td>Other non-sight threatening infections</td>
<td>3 or 4</td>
<td>21.70</td>
<td></td>
</tr>
<tr>
<td><strong>Tumours</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant - intraocular</td>
<td>2</td>
<td>71-90</td>
<td></td>
</tr>
<tr>
<td>- of the lids (low grade BCC’s)</td>
<td>3</td>
<td>51-70</td>
<td></td>
</tr>
<tr>
<td>Orbital tumours - suspected malignant</td>
<td>2</td>
<td>71-100</td>
<td></td>
</tr>
<tr>
<td>- low grade malignant or benign</td>
<td>3 or 4</td>
<td>21.70</td>
<td></td>
</tr>
<tr>
<td>Other tumours</td>
<td>2, 3 or 4</td>
<td>21.90</td>
<td></td>
</tr>
<tr>
<td><strong>Enucleation/Evisceration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant tumour or severe pain</td>
<td>2</td>
<td>71.60</td>
<td></td>
</tr>
<tr>
<td>Risk to other eye</td>
<td>2</td>
<td>71.80</td>
<td></td>
</tr>
<tr>
<td>Cosmetic</td>
<td>4 or 6</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td><strong>Retinal Disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retinal detachment with macula not detached</td>
<td>1</td>
<td>91.100</td>
<td></td>
</tr>
<tr>
<td>Retinal detachment with macula detached</td>
<td>2</td>
<td>71.90</td>
<td></td>
</tr>
<tr>
<td>Vitreous haemorrhage</td>
<td>2 or 3</td>
<td>51.90</td>
<td></td>
</tr>
<tr>
<td>Retinal pathology requiring laser photocoagulation</td>
<td>2</td>
<td>71.90</td>
<td></td>
</tr>
<tr>
<td>Retinal hole tears etc.</td>
<td>2</td>
<td>71.90</td>
<td></td>
</tr>
<tr>
<td>Retinopathy of prematurity</td>
<td>2</td>
<td>71.90</td>
<td></td>
</tr>
<tr>
<td>Diabetic retinopathy</td>
<td>2 or 3</td>
<td>51-00</td>
<td></td>
</tr>
</tbody>
</table>
OPHTHALMOLOGY
National Clinical Priority Assessment Criteria (CPAC)
FOR CATARACT SURGERY

Patient ID: Complete patient details or place patient sticker here

Nat. Hospital No.: ____________________________  Consultant: ____________________________
Name: ____________________________  D.O.B. __/__/____
Address: ____________________________

Name of Assessor: ____________________________
Date of Assessment: __/__/____

Section 1: VISUAL ACUITY SCORE

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6/9</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>6/12</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>6/18</td>
<td>6</td>
<td>10</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>6/24</td>
<td>7</td>
<td>11</td>
<td>15</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>6/36</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>22</td>
<td>26</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>6/60</td>
<td>9</td>
<td>13</td>
<td>17</td>
<td>23</td>
<td>28</td>
<td>32</td>
<td>34</td>
</tr>
<tr>
<td>CF/HM</td>
<td>10</td>
<td>14</td>
<td>19</td>
<td>25</td>
<td>30</td>
<td>34</td>
<td>36</td>
</tr>
</tbody>
</table>

Max 6 points

Section 2: CLINICAL MODIFIERS

If BCVA better than 6/24 in eye to be operated on, add 5 points only if posterior sub-capsular cataract present - to offset good VA

If non-cataract pathology reducing vision, subtract up to 50% of VA points
(Posterior segment disease requiring prompt treatment to be ranked by disease to be treated)

Section 3: SEVERITY OF VISUAL IMPAIRMENT

A. Gross visual function: Any difficulty, even with glasses, recognising faces, watching TV, cooking, playing sports, cards etc.

POINTS:

| No difficulty | 0 | 1 | 2 | 3 | 4 | 5 |

Difficult

Impossible

Max 6 points

B. Driving/Mobility: Choose one pathway

Section 4: ABILITY TO WORK, GIVE CARE, LIVE INDEPENDENTLY

POINTS:

| No difficulty | 0 | 1 | 2 | 3 | 4 | 5 |

Difficult

Impossible

Max 6 points

Section 5: OTHER DISABILITY

POINTS:

| No disability | 0 | 1 | 2 | 3 | 4 | 5 |

Moderate disability

Severe disability

Max 5 points

State disability: ____________________________

Sections 4 & 5 only apply when sections 1 + 2 + 3 < 50 (Maximum points allowed)

The maximum score is 50 points

TOTAL SCORE

OUTCOME:  To GP  [ ]  Waiting List  [ ]  Booked  [ ]
ORTHOPAEDICS

FOCUS AND SCOPE:
Congenital abnormality, disease or trauma of the musculoskeletal system including rheumatoid disease, when surgery appears to be the modality of choice. Opinions and advice for primary care practitioners, assessment, specialist investigations and treatment as appropriate.

SPECIFIC REFERRAL INFORMATION:
If the injury older than 7 days – ACC referrals require the ACC Case Manager’s approval prior to being accepted by MidCentral Health.

TESTS REQUIRED:
Appropriate plain x-rays.

CONTACT:
Phone: (06) 350 8630
Postal: Ambulatory Care Centre
        Palmerston North Hospital
        Private Bag 11036
        Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 4.30 pm.
## National Access Criteria for First Assessment (ACA)

**Category Definitions:** These are recommended guidelines for NHS specialists prioritising referrals from primary care.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td>* Suspected malignancy</td>
</tr>
<tr>
<td></td>
<td>* Disc prolapse with significant neurological deficit</td>
</tr>
<tr>
<td></td>
<td>* Extreme functional impairment – community living at risk</td>
</tr>
<tr>
<td></td>
<td>* Trauma not requiring immediate intervention</td>
</tr>
<tr>
<td></td>
<td>* Major risk of permanent disability through delay</td>
</tr>
<tr>
<td>Urgent</td>
<td>* Severe functional impairment – requiring considerable assistance ADL</td>
</tr>
<tr>
<td></td>
<td>* Severe pain – sleep regularly disturbed, poor analgesic control</td>
</tr>
<tr>
<td></td>
<td>* Serious congenital condition in infants</td>
</tr>
<tr>
<td></td>
<td>* Significant risk of permanent disability through delay</td>
</tr>
<tr>
<td>Semi-Urgent</td>
<td>* Moderate functional impairment – some assistance required ADL</td>
</tr>
<tr>
<td></td>
<td>* Moderate pain – some sleep disturbance, modest analgesic control</td>
</tr>
<tr>
<td></td>
<td>* Moderate risk of permanent disability through delay</td>
</tr>
<tr>
<td></td>
<td>* Employment seriously restricted</td>
</tr>
<tr>
<td></td>
<td>* Rapidly progressive deformities</td>
</tr>
<tr>
<td>Routine</td>
<td>* Mild - moderate functional impairment – restriction of leisure activity, no assistance for ADL</td>
</tr>
<tr>
<td></td>
<td>* Mild - moderate / episodic pain – satisfactory analgesic control</td>
</tr>
<tr>
<td></td>
<td>* Low risk of permanent disability through delay</td>
</tr>
<tr>
<td></td>
<td>* Employment being maintained</td>
</tr>
<tr>
<td></td>
<td>* Slowly progressive deformities</td>
</tr>
<tr>
<td>Low Priority</td>
<td>* No / minimal functional impairment – no restriction of leisure activity, no assistance for ADL</td>
</tr>
<tr>
<td></td>
<td>* No / minimal / episodic pain – analgesics seldom required</td>
</tr>
<tr>
<td></td>
<td>* No / minimal risk of permanent disability through delay</td>
</tr>
<tr>
<td></td>
<td>* Employment not threatened</td>
</tr>
<tr>
<td></td>
<td>* No / very slowly progressive deformities</td>
</tr>
<tr>
<td></td>
<td>* Patient seeking second opinion / reassurance</td>
</tr>
<tr>
<td>Not Seen</td>
<td></td>
</tr>
</tbody>
</table>

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or emailed. The times to assessment may vary depending on size and staffing of the hospital department.
<table>
<thead>
<tr>
<th>Orthopaedic Codes</th>
<th>Abbrev</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand/wrist</strong></td>
<td></td>
</tr>
<tr>
<td>amputation finger/thumb</td>
<td>HW1</td>
</tr>
<tr>
<td>arthrodesis</td>
<td>HW2</td>
</tr>
<tr>
<td>arthrodesis finger</td>
<td>HW3</td>
</tr>
<tr>
<td>arthrodesis thumb/p MCP/CMC</td>
<td>HW4</td>
</tr>
<tr>
<td>arthroplasty base thumb</td>
<td>HW5</td>
</tr>
<tr>
<td>arthroplasty MCP/p</td>
<td>HW6</td>
</tr>
<tr>
<td>carpal tunnel release/ulnar nerve decompression wrist</td>
<td>HW7</td>
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<tr>
<td>Dupuytren’s fasciectomy</td>
<td>HW8</td>
</tr>
<tr>
<td>excision distal segment ulna</td>
<td>HW9</td>
</tr>
<tr>
<td>flexor/extensor tendon repair (1°/2°/graft)</td>
<td>HW10</td>
</tr>
<tr>
<td>ligament reconstruction/capsular repair</td>
<td>HW11</td>
</tr>
<tr>
<td>opponents transfer</td>
<td>HW12</td>
</tr>
<tr>
<td>osteotomy phalangeal/metacarpal</td>
<td>HW13</td>
</tr>
<tr>
<td>synovectomy MCP</td>
<td>HW14</td>
</tr>
<tr>
<td>synovectomy wrist</td>
<td>HW15</td>
</tr>
<tr>
<td>tendon transfer radial nerve palsy</td>
<td>HW16</td>
</tr>
<tr>
<td>Volkmann’s contracture</td>
<td>HW17</td>
</tr>
<tr>
<td><strong>Elbow</strong></td>
<td></td>
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<tr>
<td>anterior transfer ulnar nerve</td>
<td>E1</td>
</tr>
<tr>
<td>arthrodesis/arthroplasty</td>
<td>E2</td>
</tr>
<tr>
<td>arthroscopy</td>
<td>E3</td>
</tr>
<tr>
<td>anticondyly</td>
<td>E4</td>
</tr>
<tr>
<td>excision radial head</td>
<td>E5</td>
</tr>
<tr>
<td>posterior interosseous nerve release</td>
<td>E6</td>
</tr>
<tr>
<td>supracondylar osteotomy</td>
<td>E7</td>
</tr>
<tr>
<td>synovectomy</td>
<td>E8</td>
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<tr>
<td>tennis/golfer’s elbow</td>
<td>F4</td>
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<tr>
<td><strong>Shoulder</strong></td>
<td></td>
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<tr>
<td>acromioclavicular dislocation</td>
<td>SH1</td>
</tr>
<tr>
<td>arthrodesis/arthroplasty</td>
<td>SH2</td>
</tr>
<tr>
<td>arthroscopy</td>
<td>SH3</td>
</tr>
<tr>
<td>arthrolysis</td>
<td>SH4</td>
</tr>
<tr>
<td>decompression rotator cuff tendinitis (acute/chronic)</td>
<td>SH5</td>
</tr>
<tr>
<td>excision subacromial</td>
<td>SH6</td>
</tr>
<tr>
<td>repair recurrent dislocation</td>
<td>SH7</td>
</tr>
<tr>
<td>repair rupture rotator cuff</td>
<td>SH8</td>
</tr>
<tr>
<td><strong>Foot/Ankle</strong></td>
<td></td>
</tr>
<tr>
<td>arthrodesis</td>
<td>FA1</td>
</tr>
<tr>
<td>arthroplasty ankle</td>
<td>FA2</td>
</tr>
<tr>
<td>arthroscopy ankle</td>
<td>FA3</td>
</tr>
<tr>
<td>arthrolysis ankle</td>
<td>FA4</td>
</tr>
<tr>
<td>claw/hammer/correction CTEV</td>
<td>FA5</td>
</tr>
<tr>
<td>hallux rigidus correction</td>
<td>FA6</td>
</tr>
<tr>
<td>hallux valgus correction</td>
<td>FA7</td>
</tr>
<tr>
<td>ingrown toenail</td>
<td>FA8</td>
</tr>
<tr>
<td>ligament reconstruction ankle</td>
<td>FA9</td>
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<tr>
<td>metatarsalgia</td>
<td>FA10</td>
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<tr>
<td>osteotomy lesser metatarsals</td>
<td>FA11</td>
</tr>
<tr>
<td>repair Achilles tendon (1°/2°)</td>
<td>FA12</td>
</tr>
<tr>
<td>repair tendon (1°/2°)</td>
<td>FA13</td>
</tr>
<tr>
<td>subtalar/triple arthrodesis</td>
<td>FA14</td>
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<tr>
<td>transfer tibialis anterior/posterior</td>
<td>FA15</td>
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<tr>
<td><strong>Hip</strong></td>
<td></td>
</tr>
<tr>
<td>arthrodesis</td>
<td>H1</td>
</tr>
<tr>
<td>arthroplasty</td>
<td>H2</td>
</tr>
<tr>
<td>DDH management</td>
<td>H3</td>
</tr>
<tr>
<td>excision arthroplasty</td>
<td>H4</td>
</tr>
<tr>
<td>proximal femoral osteotomy</td>
<td>H5</td>
</tr>
<tr>
<td>revision arthroplasty</td>
<td>H6</td>
</tr>
<tr>
<td><strong>Knee</strong></td>
<td></td>
</tr>
<tr>
<td>arthroplasty/distal femoral or proximal femoral osteotomy</td>
<td>K1</td>
</tr>
<tr>
<td>osteotomy/arthrodesis</td>
<td>K2</td>
</tr>
<tr>
<td>arthroscopy</td>
<td>K3</td>
</tr>
<tr>
<td>arthrotomy</td>
<td>K4</td>
</tr>
<tr>
<td>elevation tibial tuberosity</td>
<td>K5</td>
</tr>
<tr>
<td>excision patella</td>
<td>K6</td>
</tr>
<tr>
<td>ligament reconstruction</td>
<td>K7</td>
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<tr>
<td>meniscectomy</td>
<td>K8</td>
</tr>
<tr>
<td>patella recurrent dislocation</td>
<td>K9</td>
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<tr>
<td>release retinaculum, dislocation etc</td>
<td>K10</td>
</tr>
<tr>
<td>revision arthroplasty</td>
<td>K11</td>
</tr>
<tr>
<td><strong>Spine</strong></td>
<td></td>
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<tr>
<td>cervical rib excision</td>
<td>SP1</td>
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<tr>
<td>corpectomy</td>
<td>SP2</td>
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<tr>
<td>correction spinal deformity</td>
<td>SP3</td>
</tr>
<tr>
<td>decompression stenosis</td>
<td>SP4</td>
</tr>
<tr>
<td>discectomy</td>
<td>SP5</td>
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<tr>
<td>spinal fusion (cervical/lumbar/lumbar)</td>
<td>SP6</td>
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<tr>
<td><strong>General</strong></td>
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<tr>
<td>cerebral palsy surgery</td>
<td>G1</td>
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<tr>
<td>chronic osteoarthritis</td>
<td>G2</td>
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<tr>
<td>compartment decompression</td>
<td>G3</td>
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<tr>
<td>correction congenital deformity upper/lower limb</td>
<td>G4</td>
</tr>
<tr>
<td>excision ganglion</td>
<td>G5</td>
</tr>
<tr>
<td>excision neuraxis</td>
<td>G6</td>
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<tr>
<td>excision of exostosis</td>
<td>G7</td>
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<tr>
<td>limb lengthening</td>
<td>G8</td>
</tr>
<tr>
<td>nerve suture (1°/2°)</td>
<td>G9</td>
</tr>
<tr>
<td>non-union/malunition any bone</td>
<td>G10</td>
</tr>
<tr>
<td>removal metal</td>
<td>G11</td>
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<tr>
<td>stenosing tenosynovitis</td>
<td>G12</td>
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<tr>
<td>tumour resection — benign</td>
<td>G13</td>
</tr>
<tr>
<td>tumour resection — malignant</td>
<td>G14</td>
</tr>
</tbody>
</table>
OSTOMY SERVICE

FOCUS AND SCOPE:
Assessment, education, nursing assistance and supply of consumables for people awaiting surgery for a stoma or who already have a stoma.

SPECIFIC REFERRAL INFORMATION:
The medical and surgical history including the operation record, the type of stoma, the diagnosis, and the prognosis.
The current treatment regime.
Any complications.
The current prescription for consumables if known.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8111 or 0800 001 491
Fax: (06) 350 8102
Email: janet.spring@midcentral.co.nz
      maria.stapleton@midcentral.co.nz
Postal: Ostomy Service
       MidCentral Health
       Private Bag 11036
       Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 5.00 pm, Monday to Friday.
FOCUS AND SCOPE:

Physiotherapy Services offer inpatient, outpatient and community services under Ministry of Health Contracts and also acute presentations under Accident Insurance regulations. Referrals are accepted for clients of all ages. The aim of service provision is to assist in the maximisation of the rehabilitation potential and enable clients to self manage via education, exercise and therapy.

SPECIFIC REFERRAL INFORMATION:

Non Accident Related Referrals:
- Social support/history
- Reason for referral
- Diagnosis
- Presenting complaints
- Objective outcome
- Other referrals sent
- Adequate medical history – present and past
- Contact person, especially for Community referrals.

Accident Related Referrals (all the above PLUS):
- Case Manager (if known)
- Date of injury
- Employer
- Read Code
- Previous treatments for the same injury.

TESTS REQUIRED:

- X-rays when applicable
- Result
- Location of x-rays e.g. Broadway, MidCentral Health.

OTHER INFORMATION:

No surcharges for accident related referrals/patients.

CONTACT:

Phone:  (06) 350 8182 or 0800 741 222
Fax:    (06) 350 8122
Email:  CentralReferral@midcentral.co.nz

Postal: Central Referral Management
Rehabilitation Service
Palmerston North Hospital
Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:

8.00 am – 5.00 pm, Monday to Friday.
PODIATRY

FOCUS AND SCOPE:
Assessment, diagnosis, treatment, education and recommendations in relation to foot care and related problems for people referred with peripheral vascular disease, diabetes mellitus and lower limb peripheral neuropathy, ulcers and pressure lesions. Includes: doppler checks, ankle brachial index assessments, in-growing toenails, hypertrophied nails, hyperkeratosis, keratotic skin lesions, ulcers, verrucae/warts, orthotic problems, biomechanical problems e.g. bunions.

SPECIFIC REFERRAL INFORMATION:
Detailed history in relation to medical problems such as heart disease, diabetes, hypertension, stroke etc. Previous foot and limb problems. Injuries, footdrop, amputation of digits etc. Current medications.

TESTS REQUIRED:
- Recent blood sugar series
- HbAlc
- Total cholesterol, CBC, ESR, Reticulocytes
- Blood pressure.

OTHER INFORMATION:
This is a clinic based service provided from most of MidCentral Health’s sites.

CONTACT:
Phone: (06) 350 8610 or 0800 800 745 Postal: Central Referral Management
Fax: (06) 350 8453 Rehabilitation Service
Email: CentralReferral@midcentral.co.nz Palmerston North Hospital

HOURS OF ATTENDANCE:
8.30 am – 5.00 pm, Monday to Friday.
FOCUS AND SCOPE:

Provides services and programmes that are delivered to all preschools and schools. It is expected that the intensity of service will be higher in Lower Decile rating schools. The service fits within the Child Health Strategy and is complementary to any other service provided by other health providers and services. Range of services provided includes the following elements:

- Hearing and vision screening
- Assessment and referral services
- Year 7 immunisations
- Adolescent clinics and self referral clinics.

SPECIFIC REFERRAL INFORMATION:

The service is universal and is available to all school and pre school age children. The service can be accessed by referral from schools, parents/caregivers, other health providers, other sectors or self. All bases have an answer phone/call service.

TESTS REQUIRED:

Nil.

OTHER INFORMATION:

Service remains operational during school holidays. The service is provided in the school or preschool or if appropriate in the child’s home or the nurses’ base.

CONTACT:

Phone: (06) 355 0743
Fax: (06) 355 0747
Postal: Public Health Nursing
Palmerston North Hospital
PO Box 2056
Palmerston North

HOURS OF ATTENDANCE:

8.30 am – 5.00 pm, Monday to Friday.
PUBLIC HEALTH REGULATION TEAM

FOCUS AND SCOPE:
All diseases and poisonings notifiable to the Medical Officer of Health as per the 1st and 2nd Schedule of the Health Act 1956.
Services include:
• Investigation, assessment, surveillance, contact tracing, monitoring and intervention as appropriate.

SPECIFIC REFERRAL INFORMATION:
All communicable, infectious and vaccine preventable diseases must be notified including suspected cases.

TESTS REQUIRED:
Lab confirmation of diagnosis if appropriate.

OTHER INFORMATION:
• Health Districts covered: Manawatu (includes Tararua and Horowhenua), Wanganui and Southern Ruapehu
• Personnel are; Medical Officer of Health, Communicable Diseases Nurse Practitioner, Health Protection Officers, Smokefree Officer.

CONTACT:
Phone: (06) 350 9110
Fax: (06) 350 9111
Email: publichealthreg@midcentral.co.nz
Postal: Public Health Services Community Health Village P O Box 2056 Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 4.30 pm (Office)
24 hour on call Health Protection Service.
RADIOLOGY

FOCUS AND SCOPE:

Diagnostic Imaging for:
• Plain x-rays
• Barium studies
• Intravenous Urography
• Mammography
• Ultrasound.

SPECIFIC REFERRAL INFORMATION:

• Referral Guidelines:
  Please refer to GUIDELINES FOR DOCTORS, 2003 (P.N. Hospital).
  “Making the Best Use of a Department of Clinical Radiology and Nuclear Medicine”
• Requests – We require a “hard copy” request, even for urgent requests, before examining the patient.
• Doctor and patient details – Full and legible patient and doctor identification and addresses. This includes your “Practice” address in case of Locums and NZ Reg. ACC ______ No.
• Clinical Information – Completing relevant clinical information will enable us to give your patient the most appropriate priority and allow us to perform the most appropriate examination. Please refer to the “Guidelines for Doctors.”
• Appointments – General Radiography:

  Please send patients during these hours:
  Monday to Tuesday  8.30 am – 4.00 pm
  Wednesday & Thursday  9.30 am – 4.00 pm
  Friday  8.30 am – 4.00 pm

  After midday – can be arranged by appointment only.
  All other requests – An appointment will be made for your patient.

Note: Radiology works to a tight schedule and it is important that patients allow additional time for parking and arrive on time.

SPECIAL REQUIREMENTS:

Urgent requests and results – If you require an urgent (same day) report on a patient’s examination, please contact a radiologist, Registrar or Senior MRT, and discuss the case with them. This way the matter is most likely to be given the appropriate attention. We will need to know how we can contact you with the result.
Written requests for urgent reports will not be given priority.
Patient preparation – Special preparations are sent for all examinations excluding general x-rays and some Ultrasound scans.
PLEASE INFORM US OF PATIENTS WITH MEDICAL CONDITIONS, such as diabetes, for which diet and medication will be affected by examination preparations. Patients being referred for an IVU who are diabetic, have known renal disease or are over the age of 60 years must have had a creatinine level within the previous six months.
OTHER INFORMATION:

Results:
• To allow the patient’s medical advisor to discuss the result with the patient and to interpret it in the light of other clinical information, we do not normally give results directly to patients and Medical Radiation Technologists (Radiographers) are instructed not to give their opinions.
• Hard copy results are normally dispatched within 24 hours of being reported. (Electronic reports are available via Healthlink or for Horowhenua Radiology reports via Éclair or fax.) There may be delays in reporting due to a shortage of radiologists from time to time.

CONTACT:
Enquiries: (06) 350 8700  Postal: Palmerston North Hospital
Fax: (06) 350 8711  Private Bag 11036
                   Palmerston North
FOCUS AND SCOPE:
Non surgical management of malignant disease, other than Palliative Care. The Service includes the separate disciplines of Radiation Oncology and Medical Oncology. Patients may be referred for assessment for treatment or discussion on management issues.

SPECIFIC REFERRAL INFORMATION:
Referrals must specify “Radiation Oncology” or “Medical Oncology” Clinic. The Service functions primarily as a tertiary referral for the treatment of cancer. A firm pathological diagnosis of cancer is expected to have been made prior to referral. The following opportunities for General Practitioner referral may occur:
1. The patient has suspected but unproven malignancy. Usually such patients should be referred to appropriate surgical or medical services for diagnosis. If it appears appropriate to refer directly to Oncology Services, this should be discussed with an Oncologist prior to referral.
2. Suspected first or subsequent recurrence of a cancer; appropriate and available tests to confirm or refute suspicion should be performed, e.g. blood tests, x-rays, simple biopsy. Initial referral should be to specialist following that patient.
3. Exacerbation of symptoms due to a known cancer; refer to appropriate specialist following that patient, or consider referral to Palliative Care services.
4. Patient experiencing complications of treatment. Refer to treating Specialist/Service. Note some such complications constitute a medical emergency, e.g. potential neutropenic sepsis and telephone consultation/immediate hospital referral may be required.
5. Patient treated elsewhere referred for follow-up; if ongoing follow-up required, referral should be to the type of specialist previously following patient, e.g. Surgeon/Radiation Oncologist/Medical Oncologist.
Note: Skin malignancy. The department is no longer able to accept primary referrals for the management of suspected skin cancers and these should be referred initially to Surgical or Dermatological Services.

TESTS REQUIRED:
Results of all pertinent investigations done, particularly relevant blood tests and imaging results. Hard copies of reports would be appreciated. For new patient referrals the following are absolutely required:
a) Copies of all relevant pathology reports (Histology/Cytology)
b) Results of all relevant imaging tests, e.g. x-rays/CT/MRI/Bone Scan.
Note: If actual copies of reports are not available, then information which will allow access to these reports is required, e.g. where the patient has been imaged or treated, dates of treatment, pathology reference numbers.
OTHER INFORMATION:
X-rays/scans and reports held by patient are to be brought to initial appointment.
New patient referrals: In addition to specific investigations mentioned above, also required are all details of previous treatment including previously involved specialists, site where treatment occurred, ie other hospitals/clinics, dates of treatment.
MidCentral Health Region – frequent clinics at Palmerston North Hospital, monthly Radiation Oncology clinics at Horowhenua and Dannevirke Hospitals, and monthly Medical Oncology clinics at Horowhenua Hospital.

CONTACT:
Phone:  (06) 350 8430                Postal:  Regional Cancer
Fax:     (06) 350 8431                Treatment Service
                  Palmerston North Hospital
                      Private Bag 11036
                           Palmerston North
FOCUS AND SCOPE:
Rehabilitation Services for patients aged 15–65 years who have a physical disability. Comprehensive multidisciplinary rehabilitation programmes are provided which aim to create positive, challenging ways for patients to achieve their maximum potential. Focus is on patients with a neurological or musculoskeletal diagnosis at the severe end of the spectrum, although individual referrals are all considered. The Rehabilitation Centre is contracted to provide rehabilitation services under a Ministry of Health funded DSS Contract and also provide assessment, treatment and rehabilitation services to ACC claimants.

Since 1 July, 1999, changes to the Accident Insurance Act 1998, dictate that ACC is responsible for funding follow up patient services (including rehabilitation) six weeks and onwards following onset of an acute event. Funding permission is required from ACC patients in this category.

SPECIFIC REFERRAL INFORMATION:
- Has your patient an active ACC claim?
- Is the patient’s ACC Case Manager aware of the referral? If not, it is recommended that funding permission is sought from the Case Manager. This should accompany the referral in order to avoid delays which may arise whilst funding permission is being pursued.
- Have you referred this patient to any other services (e.g. Neurology Clinic, Rheumatology Clinic, Services for the Elderly)?
- Is this patient being seen by any private service providers?

INFORMATION REQUIRED:
- Up to date medical information e.g. interventions trialled, current medication.
- Any relevant documentation (e.g. previous specialist opinion, CT/MRI reports, laboratory investigations).
- Details regarding any previous input from HHS or private rehabilitation providers.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8033  Postal: Central Referral Management
Fax: (06) 350 8122  Rehabilitation Service
Email: CentralReferral@midcentral.co.nz  Palmerston North Hospital
Postal: Central Referral
     Management
     Rehabilitation Service
     Palmerston North Hospital
     Private Bag 11036
     Palmerston North
REHABILITATION CENTRE REFERRAL PROCESS

GP decision to refer for Rehabilitation

ACC Claimant

NO

YES

Referrer to send request to individual's ACC Case Manager

Forward directly to: REHAB CENTRE

Referral with documented ACC approval to be forwarded to Rehab Centre

Case Manager to notify GP/Referrer of declined support

Approved by Case Manager

YES

NO

GP referral letter indicates declined ACC support
RESPIRATORY MEDICINE

FOCUS AND SCOPE:
Assessment and investigation of patients presenting with respiratory disease. Patients can be referred for respiratory function tests. Referrals can also be made to the Sleep Disordered Breathing Clinic. Requests for assessment for need for home oxygen are made to this service. Referrals can also be made for Specialist Asthma and Rehabilitation Nurse Services.

SPECIFIC REFERRAL INFORMATION:
- Detailed clinical history
- Previous x-rays – where taken
- Current medications
- Results of respiratory function tests
- Relevant blood, mantoux and sputum tests.

TESTS REQUIRED:
- Spirometry.

CONTACT:
Phone:  (06) 350 8616
Fax:  (06) 350 8647
Asthma:  (06) 350 8007
Home O₂ Specialist:  (06) 350 8008
Sleep Disordered Breathing Service (requires referral form):  (06) 350 8616
Respiratory Technician:  (06) 350 8009

HOURS OF ATTENDANCE:
8.00 am – 4.30 pm.
### National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

1. **Urgent**
   - seen immediately or within 1 to 2 weeks
2. **Semi-Urgent**
   - within 2 to 6 weeks
3. **Routine**
   - within 2 to 12 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

### NATIONAL REFERRAL GUIDELINES: RESPIRATORY MEDICINE

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Urgent</strong></td>
<td>• Major clinical risk if treatment delayed</td>
<td>• Possible infectious TB</td>
</tr>
<tr>
<td></td>
<td>• Serious infections</td>
<td>• Severe COPD with complications</td>
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<td></td>
<td>• Disabling, stable or gradually progressive airways disease not requiring admission but needing specialist assessment.</td>
<td>• Gradually worsening chronic asthma.</td>
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<td></td>
<td>• Suspected Neoplasic disease with significant symptoms</td>
<td>• Suspected lung cancer</td>
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<tr>
<td></td>
<td>• Other significant respiratory pathology</td>
<td>• Recent significant haemoptysis</td>
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<td></td>
<td></td>
<td>• SVC obstruction</td>
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<td></td>
<td></td>
<td>• Pleural effusion</td>
</tr>
<tr>
<td><strong>2. Semi-Urgent</strong></td>
<td>• Major/moderate function impairment with moderate clinical risk requiring assessment and review</td>
<td>• Other categories of TB, e.g. reactivation</td>
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<td></td>
<td>• Less severe variants of Cat. 1</td>
<td>• Assessment for domiciliary oxygen</td>
</tr>
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<td></td>
<td>• Major GP diagnostic respiratory dilemmas</td>
<td>• Dyspnoea of uncertain cause</td>
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<td></td>
<td>• Disorders of excessive sleepiness</td>
<td>• Respiratory disease associated with or complicating extra pulmonary disease</td>
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<td></td>
<td>• Extra-pulmonary thoracic disorders</td>
<td>• Severe OSA</td>
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<td></td>
<td>• Paediatric - adult transfer</td>
<td>• Respiratory muscle impairment</td>
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<td></td>
<td></td>
<td>• Major chest wall deformity</td>
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<td></td>
<td></td>
<td>• Extensive pleural disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cystic Fibrosis</td>
</tr>
<tr>
<td><strong>3. Routine</strong></td>
<td>• Past history suggests moderate functional impairment where clinical assessment and review may be beneficial.</td>
<td>• Moderate Obstructive Sleep Apnoea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moderate COPD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pleural plaques</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;Stable&quot; radiologic abnormalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chronic cough</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asymptomatic parenchymal disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mantoux +ve healthcare workers, other TB contacts, Refugees (This is currently a Public Health responsibility)</td>
</tr>
</tbody>
</table>
FOCUS AND SCOPE:
This is a general rheumatology service. Indications for referral include, but are not limited to, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and autoimmune connective tissue diseases such as lupus, scleroderma, polymyalgia, gout, pseudogout, soft tissue rheumatism such as fibromyalgia syndrome, motor fascitis, osteoarthritis etc.

SPECIFIC REFERRAL INFORMATION:
• Current medication
• History of rheumatology problem
• List of other significant problems.

TESTS REQUIRED:
Where indicated –
• CBC with ESR
• Renal, liver and bone profiles
• Urate levels
• ANA, Rheumatoid & CRP.

OTHER INFORMATION:
Patients with acute traumatic lesions, mechanical problems and those probably requiring surgery or arthroscopy are best referred to the Orthopaedic Service.

CONTACT:
Phone: (06) 350 8610
Postal: Ambulatory Care Centre
      Palmerston North Hospital
      Private Bag 11036
      Palmerston North

HOURS OF ATTENDANCE:
8.30 am – 5.00 pm.
### National Access Criteria for First Assessment [ACA]

**Category Definitions:** These are recommended guidelines for RHT specialists prioritizing referrals from primary care.

1. **Immediate** - within 24 hours
2. **Urgent** - within 4 weeks
3. **Semi-Urgent** - within 12 weeks
4. **Routine** - within 24 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>• Acute Rheumatological Emergencies with threat to life or major organs</td>
<td>• Giant Cell arteritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Systemic Vasculitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SLE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Septic arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polyarticular gout and systemically unwell</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>• Potential destructive inflammatory arthritis requiring early DMARD</td>
<td>• Seropositive RA</td>
</tr>
<tr>
<td></td>
<td>treatment or corticosteroids</td>
<td>• Polymyalgia rheumatica</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polyarticular gout</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inflammatory polyarthritis</td>
</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>• Suspected inflammatory rheumatological problems</td>
<td>• Acute soft tissue problems requiring intervention</td>
</tr>
<tr>
<td></td>
<td>• Non-inflammatory conditions with major social impact (e.g. loss of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>employment)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Referrals from hospital specialists</td>
<td></td>
</tr>
<tr>
<td>4. Routine</td>
<td>• Non-inflammatory disease</td>
<td>• Osteoarthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Soft Tissue Rheumatism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fibromyalgia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other chronic pain syndromes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chronic osteoarthritis</td>
</tr>
</tbody>
</table>

**Note:**

1. Children are usually managed by Paediatricians with referral to Rheumatologists or a Paediatric Rheumatologist as required.
2. Prioritisation is often influenced by knowledge of an individual patient's social circumstances.
# National Clinical Priority Access Criteria (CPAC)

**Category Definitions:**

1. **Immediate** - within 24 hours
2. **Urgent** - within 1 week
3. **Semi-Urgent** - within 4 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediate</td>
<td>• Rheumatological conditions with acute medical complications.</td>
<td>• Severe Lupus</td>
</tr>
<tr>
<td></td>
<td>• Imminent organ failure/threat to life.</td>
<td>• Systemic vasculitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Septic Arthritis</td>
</tr>
<tr>
<td>2. Urgent</td>
<td>• Major functional impairment with inability to provide self care</td>
<td>• Polycrural gout</td>
</tr>
<tr>
<td></td>
<td>• Complex rheumatological disease with significant comorbidity requiring comprehensive assessment and treatment.</td>
<td>• Acute flare of rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Crisis intervention for chronically disabled arthritis patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute polyarthritis</td>
</tr>
<tr>
<td>3. Semi-Urgent</td>
<td>• Planned admission for intermittent therapy.</td>
<td>• Rheumatoid arthritis with other major organ involvement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Incipient gangrene due to Raynaud's phenomenon.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Multiple joint injection therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pagets disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intravenous immunosuppressive therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Yttrium Synovectomy</td>
</tr>
</tbody>
</table>
# Rheumatology

## National Clinical Priority Access Criteria (CPAC)

### Rehabilitation

**Category Definitions:**
1. Semi - Urgent - within 12 weeks
2. Routine - within 26 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples (not an exhaustive list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Semi - Urgent</td>
<td>• Chronic arthritis with recent exacerbations threatening independence, unresponsive to outpatient treatment</td>
<td>• Established RA with recent flare. &lt;br&gt; • OA of major joints.</td>
</tr>
<tr>
<td>2. Routine</td>
<td>• Musculoskeletal disability without threat of handicap. &lt;br&gt; • Chronic pain syndromes.</td>
<td>• Cervical/lumbar spondylosis. &lt;br&gt; • Generalised OA NOS. &lt;br&gt; • Chronic low back trouble. &lt;br&gt; • Fibromyalgia syndrome.</td>
</tr>
</tbody>
</table>

*Note: In general suitable patients for admission to a Rehabilitation programme will be those who will benefit from a multidisciplinary and holistic approach to education, self management techniques and physical therapy in addition to medical treatment. They will generally be those whose joints have been severely damaged by their arthritis.*
SEXUAL HEALTH SERVICE

FOCUS AND SCOPE:
All sexually transmitted infections – for diagnosis, education, contact tracing. Herpes and HIV counselling and education.

SPECIFIC REFERRAL INFORMATION:
• Current clinical details
• Previous relevant test results
• Previous treatment and response
• Medications and allergies.

TESTS REQUIRED:
If strong suspicion of STI (sexually transmitted infection) leave investigations for clinic.
If STI picked up on “routine” swabs, refer for contact tracing/education.

OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8602
Fax: (06) 350 8609
Email: sexualhealth@midcentral.co.nz
Postal: P O Box 10 009
Palmerston North

HOURS OF ATTENDANCE:
Phone for an appointment.
SOCIAL WORK

FOCUS AND SCOPE:

- Access to support/services to prevent hospital or residential care admission or readmission
- Crisis counselling for health related issues
- Stress/anxiety diffusion and acute grief counselling
- Advocacy
- Co-ordination of and access to support services for patient and/or caregiver
- Pregnancy counselling

SPECIFIC REFERRAL INFORMATION:

Nil.

TESTS REQUIRED:

Nil.

OTHER INFORMATION:

Nil.

CONTACT:

Phone: (06) 350 8322
Fax: (06) 350 8484
Postal: Social Work Unit
        STAR Centre
        PN Hospital
        Private Bag 11036
        Palmerston North

HOURS OF ATTENDANCE:

8.30 am – 5.00 pm, Monday to Friday.
FOCUS AND SCOPE:

The Speech-Language Therapist assists people who have communication and/or swallowing disorders, and their families to maximise independence.

Speech-Language Therapy aims to:
• make the most of the person’s remaining abilities
• assist their rehabilitation where possible
• teach them ways to help compensate for the problems
• increase their confidence in their attempts at communication
• use methods other than just speech, such as symbols, gesture and drawing
• provide support and education for the patient and carers

We work with people of varying ages, with differing needs and conditions. These might include people with neurological conditions such as stroke and traumatic brain injury and progressive diseases (such as Parkinson’s disease and Motor Neurone Disease). We work with patients who have head and neck cancer, laryngectomy and voice disorders. We also work with children who have feeding difficulties (as part of the Child Development Service).

NOTE: If initial referral information or assessment suggests that a patient requires expertise or resources that are not available at the Speech-Language Therapy Department, Palmerston North Hospital, a report with recommendations will be sent to the referrer and if appropriate, the referral will be forwarded to another institution or agency.

SPECIFIC REFERRAL INFORMATION:

• Onset and history of difficulties
• Previous Speech-Language Therapy input
• Description of problem
• Communication needs
• Relevant medical background (i.e. conditions which may have caused difficulties)
• Contact details
• Other services involved

TESTS REQUIRED:

If a person is being referred because of voice difficulties, they need to have an Ear, Nose and Throat Specialist assessment prior to referral to Speech-Language Therapy.

REFERRAL PROCESS:

A Central Referrals system is in place to process all referrals to the Speech-Language Therapy team. For outpatient and community patients, referrals need to be made by your doctor, specialist or another MidCentral Health DHB health professional.

CONTACT:

Phone:  (06) 350 8590  Postal:  Central Referrals
Fax:    (06) 350 8122  STAR Centre
E-mail: speech@midcentral.co.nz  Palmerston North Hospital
                                      Private Bag 11036
                                      Palmerston North
FOCUS AND SCOPE:
Supportlinks can assess people who meet the following broad eligibility definition as currently determined by Government policy:
“... a person who has been identified as having a physical, neurological, intellectual, sensory or age related disability (or a combination of these), which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required.”
Supportlinks has a role to assist clients with chronic high needs relating to a medical illness, who do not fit into traditional funding lines. Clients need to meet specific eligibility criteria. Please contact Access Co-ordinator, Supportlinks, for information.
• Home Support – home help and personal care.
• Residential Care – community homes, rest home, continuing “hospital” care.
• Carer Relief – home help, personal care, day care and residential respite care.

SPECIFIC REFERRAL INFORMATION:
Completion of referral form available from Supportlinks by phoning the numbers listed below.

TESTS REQUIRED:
Nil.

OTHER INFORMATION:
Areas Supportlinks operates in:
• Tararua
• Manawatu
• Horowhenua.

CONTACT:
Phone:  (06) 357 8050 or 0800 221 411
Fax:  (06) 353 5070
Email: supportlinks@midcentral.co.nz
Postal:  P O Box 188
        Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 5.30 pm, Monday to Friday.
FOCUS AND SCOPE:

- Provides consultancy advice and support to MidCentral Health on the provision of services appropriate to meet Maori health needs.
- Networks with Iwi Health Providers to assist determine the above.

SPECIFIC REFERRAL INFORMATION:

Identifying:
1. Cultural safety issues/barriers to health services
2. Tribal affiliations to determine dialect if interpreter required.
3. Clinical information eg current health problems etc.
4. If Iwi Health Provider is involved in client care, this information at time of referral could speed up response time.

TESTS REQUIRED:

Nil.

OTHER INFORMATION:

Nil.

CONTACT:

Phone: (06) 350 8210       Postal:    P O Box 2056
Fax:    (06) 350 8158       Palmerston North
Email:  maorihu@midcentral.co.nz

HOURS OF ATTENDANCE:

8.30 am – 4.30 pm, Monday to Friday.
FOCUS AND SCOPE:
Assessment, investigation and treatment of children and adults referred with urinary problems including infections, haematuria, incontinence and reproductive problems.

SPECIFIC REFERRAL INFORMATION:
Nil.

TESTS REQUIRED:

**Urinary Tract Infections in Children:**
- MSU
- KUB X-ray
- Ultrasound scan urinary tract.

**Urinary Tract Infections in Adults:**
- MSU
- KUB X-ray
- Ultrasound scan urinary tract with post micturition scan.

**Urinary Incontinence (in both male and female patients):**
- MSU
- KUB X-ray
- Ultrasound scan urinary tract with post micturition scan.

**Lower Urinary Tract Symptoms:**
- Serum electrolytes, urea and creatinine
- Free total PSA ratio (under 70 years of age only)
- MSU
- Plain x-ray abdomen
- Ultrasound scan urinary tract with post micturition scan
- IPS Score.

**Haematuria:**
- Serum electrolytes, urea and creatinine
- MSU
- Urine cytology (x3)
- Urgent IVU
- Blood pressure.

**Renal Colic:**
- Serum electrolytes, urea and creatinine
- MSU
- KUB X-ray
- Calcium, PO4, Urates.

**Male Subfertility:**
- Sperm count (x2; patient having abstained from ejaculation for five days)
- Serum FSH, LH, testosterone and prolactin
- Thyroid function, urea, electrolytes, creatinine and HbAlc.

**Testicular Pain/Lump:**
- MSU
- Ultrasound.
OTHER INFORMATION:
Nil.

CONTACT:
Phone: (06) 350 8610
Postal: Ambulatory Care Centre
Palmerston North Hospital
Private Bag 11036
Palmerston North

HOURS OF ATTENDANCE:
8.00 am – 5.00 pm.
### ASSESSMENT CRITERIA FOR FIRST SPECIALIST ASSESSMENT (ACA)

**Service Category:** UROLOGY  
**Patient Type:** Outpatient (Assessment)

**Category Definitions:**
1. **URGENT** – seen at next available clinic or within 1 week
2. **SEMI-URGENT** – seen within 2 months
3. **ROUTINE** – seen within 6 months

#### Category Definitions

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
<th>Examples</th>
</tr>
</thead>
</table>
| 1) URGENT | • Major functional impairment  
• Moderate risk of permanent damage to organ or system if consultation is delayed  
• Pain requiring narcotics or high analgesic  
• Trauma not requiring immediate attention | • Suspected testicular malignancy  
• Obstructed kidney  
• Continuous gross haematuria  
• Poorly controlled renal/ureteric colic  
• All other urological conditions which are referred against referral protocols |
| 2) SEMI-URGENT | • Functional impairment | |
| 3) ROUTINE | • Minimal risk if consultation is delayed | |

**Notes:**
- Exclusions: Cultural circumcisions, vasectomies
- Acute cases will be managed as per inpatient/admission criteria, however in situations of urgent referral (category 1) telephone contact with the on-call duty Urology Registrar is recommended.
FOCUS AND SCOPE:

The Child Development Service is a child/family focussed therapy based service. Provided are assessment, therapy and support services to babies, children, adolescents (birth – 16 years), who have or are at risk of developmental delay or have ongoing physical, intellectual, sensory disability needs.

This service incorporates a multi-disciplinary team and consists of visiting neurodevelopmental therapists, paediatric physiotherapist, paediatric occupational therapists, paediatric speech language therapist, psychologist and social worker. Strong links with the paediatricians and child health nursing service are maintained as well as links with well child providers in the community.

- The rural based visiting neurodevelopmental therapists will continue to focus on the 0-5 year age group and involve specific therapists from the team as indicated.
- P.N. based visiting neurodevelopmental therapist focuses on the 0-2 years with emphasis on support for premature infants and involving specific team members from the wider team earlier than 2 years as required.
- The speech language therapist focus is dysphagia management. Children with communication only issues should be referred directly to Group Special Education.
- The psychologist is involved as a team member in the management of children with behavioural concerns and also with the families of children with severe physical and intellectual disabilities providing strategies for the families and staff to implement.
- The social worker supports the families when environmental pressures may be impacting upon them. They may form the link for families with the wider Child Development Service team.
- Both the paediatric occupational therapist and physiotherapist offer bursts of therapy as well as assessments for long-term equipment (2-16 years).

The service currently works closely with other providers especially with education, where there are good links established.

SPECIFIC REFERRAL INFORMATION:

Referrals are accepted for children aged 0-16 years for whom there are concerns about any area of physical, intellectual, behavioural, cognitive and sensory development or disability and for related environmental solutions. All referrals are discussed and allocated weekly by the team.

Referrals for simple orthopaedic related conditions should continue to be sent to the main allied health departments.

Children with communication only issues should be referred directly to Group Special Education.

Referrals must have the consent of the patient or caregiver.

Referrals can be sent directly to the Child Development Service.

TESTS REQUIRED:

Nil.
OTHER INFORMATION:
The Child Development Service team is both home visiting and clinic based. The therapists cover the entire MDHB region with two part time visiting neurodevelopmental therapists specifically allocated to Horowhenua and Tararua areas.

CONTACT:
Phone: (06) 350 8293
Fax: (06) 350 9149
Postal: Private Bag 11 036
Palmerston North
FOCUS AND SCOPE:
The aim of the Wound Care Service is to promote healing and/or improve the quality of life for all patients with wounds in MidCentral Health and prevent non-intentional wounds occurring. This includes:
- Comprehensive, holistic assessment of all clients with wounds and advice on ongoing management
- Education to clients and family/whanau and support workers relating to the care of the wound and related issues
- Holistic assessment of clients with leg ulcers including ABPI and recommendation on treatment/referral options
- Education sessions at negotiated cost for practice nurses and/or GPs.

SPECIFIC REFERRAL INFORMATION:
The clinical signs and symptoms of the wound
Medical history including any underlying pathology or co-morbidity
Any previous history of non-healing wounds
History of current wound and present treatment
If available, wound swab result and recent FBC.

OTHER INFORMATION:
We undertake to see new patients within a maximum of four weeks, unless the referral is urgent.
If you wish the patient to be seen by the Clinical Nurse Specialist (CNS) wound care, please specify this on the referral form. Other patients will be allocated to either the CNS or the Wound Nurse.

CONTACT:
Phone: (06) 350 8495 (with answerphone)  Postal: Central Referral Management
Fax: (06) 350 8039  Rehabilitation Service
Email: CentralReferral@midcentral.co.nz Palmerston North Hospital

HOURS OF ATTENDANCE:
7.30 am – 5.00 pm, Monday to Friday.

NOTES: