



Medical Ambulatory Care Service

Outpatient Referral Guideline Fraser Coast Only

CHECK OPENING HOURS ON NEXT PAGE

Please use this guide to complete the appropriate tests so patients can be accurately triaged within the **MEDICAL** outpatients department.

Referral should include a clear indication as to why the patient is being referred along with a complete patient/family history relevant to the patient's condition or complaint and **current medication list and relevant investigations.**

All investigation results are to accompany the patient referral when sent to the MEDICAL outpatient department.

Infusion/Procedure	Baseline Requirements
Immunoglobulin Infusions for <ul style="list-style-type: none"> • Neurological conditions • Haematological conditions • Immunological conditions E.g. Intragam Privigen Flebogamma	<ul style="list-style-type: none"> • Requires Authorisation on BloodStar by referring Specialist (MADU Nurse will be able to confirm if this is done) • Diagnosis • Immunoglobulin Name and Dose • Route of Administration • Dose • Schedule (frequency of administration, fixed number of doses or continuing) • If any supportive medications required (Pre-med etc.) • Frequency of review by referrer • Date of last treatment if appropriate • Necessary surveillance tests, with frequency and acceptable parameters
Blood Transfusion	<ul style="list-style-type: none"> • Diagnosis • FBC • ELFT • Monitoring and regular transfusions without the need for a referral each time for patients with Transfusion dependent conditions
Iron Infusion (Ferrinject)	<ul style="list-style-type: none"> • FBC • Iron studies in last month • Any history of previous Allergic Reaction
Difficult Venesection	<ul style="list-style-type: none"> • Diagnosis • FBC • Iron Studies • Required frequency and duration of venesection • Provision of ultrasound guided venesection
Monoclonal Antibody	<ul style="list-style-type: none"> • Diagnosis • Drug Name • Route of Administration • Dose • Schedule (frequency of administration, fixed number of doses or continuing) • If any supportive medications required (Premed etc) • Frequency of review by referrer • Date of last treatment if appropriate • Source of Prescription • PBS or Non PBS • Public or Private • Necessary consent obtained • Necessary Surveillance tests, with frequency and acceptable parameters



Bisphosphate Infusions	<ul style="list-style-type: none"> • ELFT (need Renal Function, Ca, Mg, Phos & Vit D)
Bone Marrow Aspirate	<ul style="list-style-type: none"> • Referral from a haematologist/specialist giving indication for the procedure. • Blood tests or documented clinical findings suggestive for a • Bone marrow pathology. (In this case ensure an appropriate separate referral to a haematologist/Medical OPD/ specialist is done)
Lumbar Puncture	<ul style="list-style-type: none"> • Referral from a Specialist for a non-urgent elective procedure
Paracentesis (Ascites Tap)	<ul style="list-style-type: none"> • FBC • U&E • INR

Enquiries

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