Endocrinology
Outpatient Referral Guideline

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.**

Children under the age of 16yrs should be referred to the paediatric team

All investigation results are to accompany the patient referral when sent to Medical outpatient department. Test results should be dated within three (3) months of referral date.
The medical information contained here is general information and not advice.

No warranties are given in relation to the information.
It is intended for use by registered medical practitioners only and is not for distribution to the public.

Category	Disease/Presentation	Investigations
Includes but is not limited to:	• Severe Hypocalcaemia • Severe symptomatic Hypercalcaemia (>3mmol/L) • Diabetic Ketoacidosis • Severe Hypothyroidism • Addisonian Crisis • Suspected Adrenal Crisis • Thyroid Mass with stridor • Severe Thyrotoxicosis	**Refer directly to the Emergency Department** **Do not refer to Specialist Outpatient**
Includes but is not limited to:	• Thyroid Cancer • Thyrotoxicosis – less severe symptoms • Suspected Adrenal failure • New Pituitary Tumour • Symptomatic hypercalcaemia • Possible Insulinoma • New onset severe hirsutism In females • Adrenal Mass/ Phaechromocytoma • Possible Cushing's Syndrome • New male hypogonadism • Newly diagnosed T1DM • Prolactin > 3000 mIU/L • 9:00 am Cortisol < 100 mmol/L • Hypopituitarism • Diabetes Insipidus • Thyroid Nodule with malignant feature or high suspicion of malignancy	**Urgent Referral to Specialist Outpatients**

Category	Disease/Presentation	Investigations
1. Pituitary Disorder	Pituitary Tumour Please refer to Ophthalmologist/ Optometrist Or Neurosurgeon if clinically indicated/appropriate (i.e. vision impairment)	CT Scan; MRI if available; U& E's; Hormonal assay – 9:00am Se Cortisol; ACTH; TFT; prolactin (repeat if high) Other – Sex hormone profile including Testosterone, IGF-1 if indicated, U&E's.; 09:00 Cortisol; TSH/FT4/LH/FSH/Oestradiol/ Testosterone/Prolactin
	Acromegaly	Serum Cortisol/ACTH 24 hr Urine Free Cortisol (UFC)
	Cushing's Disease	TFT (Must include Free T4/TSH); Completer pituitary hormone profile; 9:00am Cortisol; LH; FSH; Prolactin, Testosterone or
	Hypopituitarism **(Urgent Referral)**	Oestradiol; GH; IGF-1
	Diabetes Insipidus **(Urgent Referral)**	U&E's; serum creatinine; serum and urine osmolality; Serum Ca and Glucose
2. Thyroid Disorder History: Recent enlargement Irradiation	Thyroid mass with palpable lymphadenopathy **(Urgent Referral)**	**Refer to surgeon**
	Thyroid Nodule	TFT (FT4/FT3/TSH), Thyroid antibodies Ultrasound thyroid Nuclear scan if indicated FNAC (Fine Needle Aspiration Cytology) if feasible
	Thyroid cancer (known/suspected)	TFT (FT4/FT3/TSH) TG/TG Ab for post thyroidectomy Ultrasound (urgent if acute) TFT Thyroid antibodies (TSH receptor & TPO abs)
	Thyrotoxicosis **(Urgent Referral)**	TSH/FT4/FT3 Thyroid Antibodies (TSH receptor & TPO Abs) Urgent ultrasound Thyroid & Nuclear scan if available
3. Pancreatic	Insulinoma/ Hypoglycaemia not related to diabetes	Blood glucose and concomitant insulin level
	Diabetes Mellitus	HbA1c, U&E, creatinine, lipid profile, urine ACR (Refer to RACGP referral guidelines, see at end)*

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4. Adrenal Disease	Addison's Disease	wACTH/ 9:00am Cortisol Renin, Aldosterone
	Cushing's Syndrome	24 hr UFC ACTH/ 9:00 am Serum Cortisol U&E's, Creatinine, FBC History of – central obesity, hypertension, osteoporosis, T2DM, emotional lability
	Adrenal Tumour/Mass	Adrenal gland dedicated CT Endocrine assay – Dexamethasone Suppression test 24 hr urine catecholamine, DHEA-S (Testosterone level, DHEA-S, 17 OHP, SHBG in females)
	Phaechromocytoma	Urinary catecholamine Plasma metanephrine and normetanephrine CT/MRI if available
5. Calcium/ Electrolyte and Metabolic Bone Disorder	Hypercalcaemia	History-malignancy, thyrotoxicosis, renal calculi U&E's, creatinine Ca – total/corrected, PO4, 1,25OH-OH Vit D,) Vit D, Serum Alb, 24 hr urine calcium ESR, FBC PTH, Se ALP, Electrophoresis DEXA, U/S KUB if available
	Hypocalcaemia With cramps/ Tetany- Refer directly to the emergency department	Ca PO4 ALP, 25OH Vit D, PTH Urine Ca
	Hyponatraemia Se Na <110 Refer directly to the emergency department	U&E's Creatinine, Urine Sodium and osmolality (urine should be done the same day with serum/blood) TFT (TSH, FT4) 9:00am Cortisol
6. Gonadal Disease	Hypogonadism – Males	Serum FSH LH Testosterone SHBG Serum Ferritin LFT PSA
	Hypogonadism – Females Amenorrhoea (after excluding pregnancy)	FSH LH, beta HCG Oestradiol, Prolactin
	Polycystic Ovarian Syndrome – Hirsutism, off pill for 6 weeks	FSH LH Oestradiol

Category	Disease/Presentation	Investigations
		SHBG Testosterone DHEAS Androstenedione FBC Lipids, 17-OHP Progesterone Ovarian U/S if available

***Diabetes (As per guideline from RACGP)**

- Type of DM and duration
- Previous therapy used to treat diabetic
- Any complications and screening
- Allied Health reviews e.g. Dietitian, Diabetic Educator
- Health Information
- HTN (Hypertension)

If patient is referred for commercial driving licence, please advise patient to bring glucometer and or recent BGL diary/records within 3 months when attending the clinic.

- Smoking, Lipids
- Pathology as above

T1DM –

Anti transglutaminase antibodies

IgA, Coeliac abs

T2DM –

Note:

1. Newly diagnosed diabetes (T2) without significant hyperglycaemia should be able to be managed by the GP and not require specialist referral.
2. If pregnant, please refer to antenatal high risk Clinic (i.e. Telehealth with RBWH in addition to referral to ANC at HBH Specialist Outpatients Department.

Enquiries	Monday to Friday, 9am to 4pm	
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