Information required for a referral to be processed

All of the requirements below need to be completed prior to submitting the referral

For all referrals: The following must be in place (if not, send back to PCP)
1. Detailed description of patient problem
2. Clear clinical question (not "evaluate and treat")
3. If patient seen in emergency room
    a. Completed report from ER doctor
    b. Any labs or imaging that was done

Specialty	Required Information
Allergy and Asthma	• Must have trial of antihistamines and nasal sprays (for rhinitis) or inhalers
Audiology	• Hearing loss o Needs to have failed hearing test in office
Cardiology	**Urgent referrals- Call specialty office to review referral** • Chest pain- EKG must be completed and attached • Hypertension o Do not refer; unless associated with chest pain or uncontrolled congestive heart failure • Heart murmur- needs ECHO (request through diagnostic imaging)
Dermatology	Acne o Refer only for severe cystic acne or failed topical treatment with oral antibiotics Rashes o Failed treatment Lesions concerning for malignancy o biopsy prior to referral, except if on face or large pigmented lesions
Endocrinology	• Recent labs: A1c, metabolic panel, lipid panel, LFT, TSH • Only refer uncontrolled type 1 or 2 patients who need insulin pump Thyroid nodule/goiter o Imaging documenting nodule/goiter o Recent thyroid hormone levels (minimally TSH) o Pathology report (if available) Thyroid Cancer o Pathology report o Thyroid levels
ENT (Otolaryngology)	**Urgent referrals- Call specialty office to review referral** • Needs audiology exam prior to referral for ear problem • Imaging should be attached for any nasal problem
Gastroenterology	• Rectal bleeding o Positive FIT test o Rectal exam (anoscopy) • Recent labs (within 6mo): CBC, PT/PTT, liver panel, pancreas enzymes • Prior endoscopies or surgeries
Infectious Disease	• Recent labs (within 6mo-1yr)
Nephrology	• Abdominal ultrasound or renal ultrasound

	• Labs:
	  ○ Renal function panel
	  ○ Comp. panel
	  ○ CBC
	  ○ Basic Metabolic panel

Neurology	• See document attached
Neurosurgery	• MRI of back within 6mo-1yr • Tried and failed physical therapy
OB/GYN	• Pap • Mammo for patient is over 40 • Biopsy (if performed or if patient has a lump)
Ophthalmology	• **No routine optometry services (schedule in Optometry clinic)** • "disease of the eye" Only
Orthopedic Surgery	• Imaging must be completed prior to creating referral (See Table 1 below)
Podiatry	• **No Bunions** • Imaging if patient has fracture
Pulmonology	• Imaging if available must be attached • PFTs
Surgery	**Urgent referrals- Call specialty office to review referral** • Abdominal pain must have imaging completed and attached

Surgery (Breast)	• Breast Cancer
	  ○ Patient must be informed prior to referral being created
	  ○ Ultrasound guided biopsy needs to be attached
	  ○ Pathology report received
	• Breast Reduction
	  ○ Must have documentation of breast problems
	  ○ If back pain because of breast, must include imaging and documentation of work-up.

Urology	• **No erectile dysfunction** • Labs within 6mo • Testicular Pain ○ Ultrasound needed

Guidelines for Referrals

For all referrals: In the **referral request** the Clinical Question to include:

1. Statement of clinical problem that drives referral
2. Pertinent Medical & Family History
3. Tried and failed therapies
4. Work up to date
5. Clinical question or request

Referral coordinators: any referral that does not meet criteria, return to PCP and let medical directors knows about problematic patterns.

Allergy

Must have trial of antihistamines and nasal sprays (for rhinitis) or inhalers (for asthma); if FNP*IP*A PCP, doctor should review prior to referral.

Breast Surgery

Breast mass over 40 - ultrasound-guided biopsy and bilateral diagnostic mammogram before referral to surgeon **Breast mass under 40** –breast ultrasound and review by medical director prior to referral

Cardiology

We can order echos, holter monitoring, event monitoring. All other non-invasive studies require cardiology consultation.

Hypertension- Do not refer:

1. Is associated with chest pain or uncontrolled congestive heart failure (GO TO ED)
2. Is associated with encephalopathy, pulmonary edema, or major vascular accidents (GO TO ED)
3. Is associated with rapidly progressive nephropathy require immediate control. (REFER TO NEPHROLOGY)

Angina/chest pain-only refer if:

1. Diagnosis is unstable angina
    - new or escalating
    - increasing angina after myocardial infarction

2. non-invasive tests suggest poor prognosis in high risk patient – i.e., EKG with diffuse ischemia but asymptomatic

Coronary artery disease, h/o M1- only refer if unresponsive angina to maximal therapy (manage risk factors -do not need routine referral)

Heart murmur- physical exam by experienced clinician to describe the murmur before referral;

- If non concerning, no ECHO
- If concerning murmur, order ECHO without referral
- If ECHO concerning, then refer only if critical murmur

Congestive heart failure - refer if CHF AND:

1. Class 3 and 4 CHF
2. Symptomatic arrhythmia, e.g., a fib, SVT, multiple PVC's
3. Valvular disease evaluating timing of surgical intervention, e.g., symptomatic and critical murmur on ECHO
4. Nonischemic cardiomyopathy

Syncope- must include thorough history and physical exam. Also consider:

- Peak flows and O2Sat monitoring
- EKG in office
- Ambulatory BP monitoring before referral.
- Orthostatic blood pressures
- Neurologic exam
- Holter monitor
- Carotid ultrasound
- Chest x-ray
- **Medical director needs to review before referral**.

Arrhythmias- Refer for:

1. patients with successful resuscitation,
2. h/o ventricular tachycardia,
3. symptomatic bradycardia,
4. recurrent paroxysmal atrial fibrillation,
5. Wolff-Parkinson-White syndrome,
6. AV Nodal Re-entrant tachycardia
7. Supraventricular arrhythmias refractory to medical treatment.
8. If has permanent pacemakers, implanted defibrillators or tachyarrhythmia device

9. If has recently undergone electrophysiological ablation

Venous stasis

- Severe for non-invasive therapy

Dermatology

Acne -Refer only for severe cystic acne or failed topical treatment with oral antibiotics

Possible skin cancer -must be biopsied prior to referral (except for large or facial lesions)

Intensely pruritic papules -refer after fails scabies treatment

Psoriasis- must fail (or have contraindication for) topical steroids and methotrexate (go to Clinical Team Lead for Co-management)

Dermatitis- only if fails treatment (referral MUST include what has been tried, for how long)

Alopecia- Only refer after checking TSH

Pigmented lesions --should be biopsied before referral unless large or on face

Do not refer (should be managed internally) spider veins, skin tags, uncomplicated cysts, Warts, lipomas, seborrheic keratosis, papillomas, hereditary hypertrichosis, molluscum, seborrheic dermatitis, pityriasis rosea, tinea

Endocrinology- (Referral Department will provide Dr. Minkoff phone for consultation)

Diabetes -only refer uncontrolled type 1, or type 2 patients who need insulin pump

Thyroid -do not refer goiter, hypothyroid, hyperthyroid (without trial of treatment). Refer for thyroid eye disease if severe or symptomatic. Refer for solitary nodule to interventional radiology after ultrasound completed if biopsy is indicated

Pituitary -email consult first. For pituitary issues, must order TSH, T3, T4, fasting cortisol, estradiol for women, testosterone for men, FSH~ LH, IGFl, Prolactin)

Hyperparathyroidism -order first: Ionized calcium, 25 vitamin D, intact PTH

Hirsutism -only refer if one of the following abnormal; do emails consult first: testosterone, LH, FSH, DHEAS, androstiendione, 17 OH progesterone, is fasting cortisol)

Osteoporosis -Do not refer. Order Bone density, Ionized Ca, Intact PTH, 2S-0H Vitamin "0, TSH, SPEPIUPEP (if younger patient, or pathologic fracture)

Hyperlipidemia -do not refer

ENT

For recurrent otitis media -referral criteria:

- Recurrent otitis media (at least three episodes in 6 mo., or 4 episodes in 12 months, failing prophylaxis
- Eustachian tube dysfunction associated with heating loss

For recurrent pharyngitis/strep throat/tonsillectomy - must have documented over five episodes of pharyngitis a year, for more than one year, with disabling symptoms that prevent normal functioning.

For sinusitis- Must have failed three week course of antibiotics, nasal rinses, and steroid nasal sprays with severe persistent symptoms, or severe recurrent sinusitis

Tinitis

- **Bilateral** start with clinic based screening and ear exam. If positive, refer for formal audiology.
- **Unilateral** same as above, add MRI before ENT referral

Vertigo- Must be persistent over 3 months

Hearing loss – start with clinic based screening and ear exam. If positive, refer for formal audiology.

Gastroenterology

For GI consultation:

Dyspepsia: must try H2 blockers, PPIs or sucralfate for 4 weeks, d/c NSAIDs prior to referral;

Hepatitis B: refer for treatment

Hepatitis C:

1. order Hepatitis A B C Panel; identify viral load and genotype, comp panel; platelets; PT/INR; then evaluate for cirrhosis.
2. Use lab results to evaluate for cirrhosis. (www.hepatitisc.uw.edu/page/clinical-calculators/apri) If screens in for cirrhosis, then also:
3. Screen for alcohol use and refer for treatment as needed
4. Screen for depression; treat and stabilize, after 6 months proceed to Step 4.
5. Refer to primary care Hep C treatment for further evaluation. (Chris Stewart/Danny Toub)

Abnormal liver enzymes:

Do not refer until lab evaluation completed (comp panel, alpha-1-antitrypsin, ferritin, ANA, CBC, ESR, ciruloplasmin as indicated)

Abdominal pain, chronic diarrhea or constipation:

- failing first line treatment
- adequate workup prior to referral

Indications for EGD:

- Dyspepsia failing H2 blockers, PPIs or sucralfate for 4 weeks; d/c NSAIDs.
- GERD for over 10 years or failing oral meds
- Dysphagia *I* Odynophagia
- Hematemesis *I* Melena
- Occult Bleeding
- Nausea *I* Vomiting, after workup
- Unintentional weight loss
- Cirrhosis with Varices, sp/UGIB
- Cancer Surveillance

Indications for colonoscopy (if done of the below, medical director to review):

- Heme + Stools, refer after anoscopy
- Rectal bleeding
- Iron Deficiency Anemia
- Follow up polyps or colon cancer
- Family History colorectal cancer (start screening at age 40)
- Ulcerative colitis/Crohn's
- Diarrhea, chronic, after negative workup
- Altered bowel movements
- Abnormal barium enema, CT must be included
- Melena
- Rectal mass

Upper abdominal pain algorithm:

Refer to GI only after 4 week trial of PPI, d/c'd NSAIDs, fecal occult blood testing, h pylori testing, abdominal ultrasound

Nephrology

Rapidly deteriorating kidney function

Evidence of glomerulo nephritis: red cell casts in UA with micro

Stage IV chronic kidney disease, to prep for renal dialysis

Chronic kidney disease with difficult to control hypertension, not responding to three medications

- Abdominal ultrasound or renal ultrasound
- Labs:

- Renal function panel
- Comp. panel
- CBC
- Basic Metabolic panel
- Uric acid level

Kidney stones – do not refer if normal kidney function. Consider urology referral if stones are persistent and recurrent.

GYN

Open access, no restrictions

Neurology (Dr. Bernstein will review all in-house referrals prior to being scheduled)

All referrals require documentation of patient history and physical exam

Headache: If over 50 y.o., order ESR. Include medication history. For migraine, trial of prophylaxis (magnesium 250 qd-tid, B12 1000 mcg qd and riboflavin 400 mg qd, additional pharmatologic interventions, beta blocker and low dose TCA; cyclic NSAIDS for reproductive age women) prior to referral.

Dizziness: Only refer severe vertigo failing first-line treatment, or balance problems with focal neuralgic signs. Do not refer "light-headedness" or chronic dizziness.

Peripheral neuropathy: Order B12, RPR, TSH, Ale, ESR, SPEP prior to referral

Dementia: Order CBC, Bl2, TSH, RPR, CMP, homocysteine, folate, and lipids prior to referral. CT of brain, if new onset.

Multiple sclerosis: MRI brain and/or spinal cord with contrast if possib1e, ANA, B12

Seizures: consult only if seizures continue despite treatment (obtain sleep-deprived EEG if possible prior to referral); consult if patient wants to stop anti-seizure meds

Do not refer: pain management, radiculopathy due to cervical or lumbar DDD, intention tremor

- ❖ Does patient need to be seen to answer clinical question (if not, consider TE/Phone consultation)

Ophthalmology

Refer:

- Proliferative retinopathy or signs of glaucoma on retinal image
- Sudden change in vision
- Eyelid lesions requiring excision or biopsy

Do Not Refer:

- o Non-proliferative retinopathy - schedule repeat retinal exam

Optometry:

- o Failed vision screen
- o Need for glasses
- o Annual dm screening

Orthopedic Surgery

FRACTURES: Urgent referral for suspected fractures – refer to emergency room for evaluation and treatment

ELBOW:

Degenerative joint disease osteoarthritis: do not refer

Olecranon bursitis -refer only if infected (emergency)

Tendonitis bursitis lateral (tennis) or medial (golfers) epicondylitis: only refer if failed conservative treatment for 6 months

Ulnar neuritis (numbness/paresthesias/weakness medial forearm to 4-5th digits): only refer if abnormal nerve conduction study or if symptoms not responsive to conservative treatment.

WRIST/HAND:

Carpal Metacarpal degenerative Joint disease: do not refer

Carpal Tunnel Syndrome: (pain, numbness and/or weakness 1-3 digits) Do metabolic workup i.e. TSH, r/o DM. Refer to Ortho if abnormal nerve conduction test and failed continuous splinting for 4 weeks, PT, failed cortisone injection (indicate for surgery: persistent numbness after treatment and/or thenar atrophy)

Degenerative joint disease/wrist: Refer only if interested in surgical fusion (failed conservative treatment)

Dequervain's tendonitis: do not refer until failed conservative treatment

Diffuse dorsal pain (OA, tendonitis): Refer only if patient wants to consider surgical fusion (failed conservative treatment, severe OA)

Dupuytren's contracture: palmar nodularity +/-finger contractures; Refer if impacting function

Ganglion cyst: only refer if painful and impacting function

Rheumatoid/Psoriatic Arthritis: refer after consultation with Rheumatology

Tendonitis/Repetitive Strain Injury: do not refer Ortho, consider Physical Medicine referral

Trigger finger/thumb: only refer if failed cortisone injection

HIP:

Degenerative Joint Disease: Refer if failed conservative treatment and x-ray documents severe DJD (AP pelvis and lateral hip)

Groin strains/buttock pain/Piriformis syndrome (deep buttock pain): Do not refer to Ortho Consider PT, PM&R, OMT, etc.

Trochanteric bursitis: do not refer; Primary care injection

KNEE:

Baker's cyst: only refer if painful or inhibits movement

Degenerative Joint disease, knee: Refer if failed conservative treatment. Get weight bearing films prior to referral

Patellofemoral Syndrome-Anterior Knee Pain: Refer only if failed conservative treatment; Merchant views along with standing AP and lat knee films prior.

Pes Anserine Bursitis- do not refer, primary care injection

Sprain, knee: Refer if unstable joint or after failed conservative treatment

SHOULDER:

Adhesive Capsulitis or Frozen Shoulder: only refer only after trial of PT and if wants to have mobilization under anesthesia

Degenerative Joint Disease: Refer for mod-severe DJD of glenohumeral or AC joint by x-ray

Dislocation/subluxation: X-rays prior to referral.

Rotator Cuff Tear: Refer if failed Physical Therapy and cortisone injection. All patients will not need or want surgery -long and painful recovery process.

Shoulder Impingement (Bursitis/Tendonitis): Refer only if failed (or intolerant of) physical therapy and cortisone injections.

Shoulder Separation -AC Separation: only refer Grade 3 or greater

BACK PAIN:

DO NOT refer to Ortho. See pain management for guidelines.

PEDIATRIC ORTHO:

Scoliosis/spinal deformity Refer for progression over 5 degrees per year or over 15 degrees. scoliosis (15-30 degrees bracing; over 30 deg surgery). Full length spine film (PA view including from neck to pelvis, inclusive) within 3 months prior to consult visit required.
If kyphosis or congenital scoliosis (e.g. bemivertebra) is Suspected. then a full length lateral view is also required.

Back pain: refer peds patients with persistent back pain (esp. if night pain, abnormal neurologic eval.); do CBC, ESR, plain X-rays and bone scan prior to referral

Knee pain, no acute injury: do not refer (nonsurgical)

Knee pain, acute injury: Signs of torn meniscus. ACL tear or fracture: swelling, locked knee, instability, joint line pain. Refer if unstable or locked knee x-rays prior to referral

Nonossifying fibroma: Do not refer

Developmental dysplasia of the hip: Refer: hip ultrasound prior.

Perthes: Refer: *AP/frog* pelvis radiograph within 3 months required

Clubfoot: URGENT No imaging studies necessary prior to referral.

Leg length inequality: > 1 cm

Slipped Capital Femoral Epiphysis: Acute--contact on-call orthopedic surgeon; Chronic- AP/frog pelvis x-ray *w/i* 3 m pre referral

Intoeing: Do not refer, use patient handout for patient reassurance.

Torticollis: Refer if failed PT -supervised program of positioning; AP, lateral and oblique cervical spine prior to referral

Leg: angular/rotational deformities No intervention. Progression normally is from genu varum (bowing) up to 3 years, to genu valgum (knock knees) up to 6 years, and close to adult alignment by age 7, Check x:rays and vitamin D level

Pain Management

BACK

Refer for lumbar epidural only if radicular pain (not just low back pain), especially acute disk or recurrent symptoms with prior benefit.

Lumbar radiculopathy (acute radicular or axial): IX under three months Urgent/emergent referrals (review with physician)

Acute Cauda Equina Syndrome: rapidly progressive neuro deficit esp with saddle anesthesia~ and bladder or bowel dysfunction: Contact on-call ortho or send to ER.

Infection with fever or chills: especially with immune compromise or IV drug use. Get CBC, CRP~ Blood C&S, X-ray.

Cancer (over 5Oy.o. or with prior history ea.): Think breast, prostate, lung, and multiple myeloma. Do X-ray, bone scan or MR1; CRP, Immune electrophoresis, CBC & smear.

Fracture in presence of trauma or risk *oC* pathologic or osteoporotic fracture. Get x-ray, establish stability of facture.

Podiatry

Diabetic foot ulcers – urgent referrals, start wound care with nurse/PCP in the meantime

Refractory foot pain, i.e.,bunions, hammer toe, neuroma, etc.

Recurrent ingrown toenail after procedure

Pulmonology/Sleep Medicine

Refer for sleep study: history and physical exam, with description of posterior pharynx.
daytime sleepiness/somnolence, snoring and obesity.
Medical director review if not meeting all three criteria.
COPD/emphysema: Refer if symptomatic despite use of Spiriva or combivent plus long-acting bronchodilator. Refer if oxygen-dependent.
Severe asthma: only if symptoms not controlled on Advair or other long-acting steroid inhaler.

Spine

Lumbar radiculopathy/referral for disk surgery:
Must have significant neurological deficit, OR must have failed conservative treatment for six months, with an MRI showing spinal stenosis or nerve root impingement.
Refer for lumbar epidural: only if radicular pain (not just low back pain), especially acute disk or recurrent symptoms with prior benefit.
Urgent/emergent referrals (review with a physician):
Acute Cauda Equina Syndrome: rapidly progressive neurology deficit esp. with saddle anesthesia, and bladder or bowel dysfunction: Contact on-call Ortho or send to ER.
Infection with fever or chills: especially with immune compromise or IV drug use. Get CBC, CRP, blood C&S, X-Ray.
Cancer (over 5O y.o. or with prior history ca): think breast, prostate, lung, and multiple myeloma. Do. X-ray, bone scan or MRI; CRP, Immune electrophoresis, CBC & smear
Fracture in presence of trauma or risk of pathologic or osteoporotic fracture: Get x-ray, establish stability of fracture.
Scoliosis: medical director review

Surgery

Do not refer for biopsies or lipoma excision if can be done internally
Cholecystitis: Either severe episode (hospitalized) or more than two episodes not controlled with diet.
Abdominal pain: requires medical director review to ensure adequate workup. Colorectal, breast and other specialty surgery -Refer within Petaluma. Referral outside Petaluma requires medical director review.

Urology

Hematuria: asymptomatic -under 40 -urine cytology q 6 months x 6, renal ultrasound Indications for cystoscopy: Over 40, or smoker, or with symptoms, refer for cystoscopy and ultrasound or CT

Epididymitis: refer if failed antibiotics and NSAIDS.

BPH: only if fails medications and limits quality of life. Total and free PSA if over 40 prior to referral

Elevated PSA: repeat fasting and free PSA prior to referral; consider email consult first

Testicular Mass: refer all solid masses; refer hydroceles, spermatoceles, and varicoceles only if large size causes intolerable symptoms.

Kidney stones: only refer if over 4mm and not passing after _ weeks, or if obstructive, fever; Abdominal x-ray with prep prior to referral

Renal failure: required for referral: metabolic panel, renal ultrasound, 24 hour urine (creat clearance, protein)

Proteinuria: Workup prior to referral: 24 hour urine; refer if >1 graml24 hours, proteinuria with hematuria in absence of UTI, creatinine over 1.5

Hypertension: Refer only if onset under 30, or if unresponsive to triple therapy.