What constitutes a good paediatric referral?

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A high quality diagnostic process would involve a number of elements:

- Gathering sufficient evidence and information
- Judging that evidence and information correctly
- Minimising delay in further investigation and onward management, particularly if the condition is serious or suspected to be serious
- Ensuring efficient use of resources
- Providing a good patient experience.

Referral:

- Referral is a key part of the GP role. It is a process with very direct consequences for patients' experience of care, and an important cost-driver in the health system.
- Approximately one in 20 GP consultations results in a referral being made to another service.
- Referrals are made for a number of reasons, including:

Reasons for referral

- to establish the diagnosis
- for treatment or an operation
- for a specified test or investigation unavailable in primary care
- for advice on management
- for reassurance.

High-quality referral involves the following elements:

- necessity – patients are referred as and when necessary, without avoidable delay
- destination – patients are referred to the most appropriate place
- process – the referral process itself is conducted well.
- referral letters contain the necessary information, in an accessible format
- patients are involved in decision-making around the referral
- all parties are able to construct a shared understanding of the purpose and expectations of the referral
- appropriate investigations and tests are performed prior to referral.

Referral content

- As the principal means of communication between the referring GP and the specialist, the content of referral letters is a crucial dimension of quality. Without adequate referral letters specialists are less able to make decisions regarding risk assessment, triaging or resource allocation (Graydon et al 2008; Bodek et al 2006).
- The necessary content of a good quality referral letter varies by referral type. Nonetheless there is a reasonably high degree of consensus about what details should usually be included (Newton et al 1991).

Common elements described in the literature include the following:

- reason for referral and expected outcome a clear statement of the purpose and expectations of the referral (Grol et al 2003; Jenkins 1993; Tattersall et al 2002; Newton et al 1991; Bodek et al 2006; Srirangalingam et al 2006)
- diagnosis (Bodek et al 2006; White et al 2003; Speed and Crisp 2005)
- clinical signs and symptoms (Patel et al 2008; Srirangalingam et al 2006)

- examination or test results (Gran et al 2000; Molloyand O'Hare 2003; Tattersall et al 2002; Newton et al 1991; Speed and Crisp 2005; Kada et al 2007; Srirangalingam et al 2006)
- medical history including important co-morbidities (Jenkins 1993; McNeill 2008; Tattersall et al 2002; Newton et al 1991; Mead et al 1999; White, Marriott 2004; Srirangalingam et al 2006)
- current and past medication (McNeill 2008; Tattersall et al 2002; Tuomisto et al 2007; Newton et al 1991; White, Marriott 2004; Srirangalingam et al 2006)
- relevant psychosocial details (Jenkins 1993; McNeill 2008; Tattersall et al 2002; Mead et al 1999; White, Marriott 2004)
- of

Paediatric outpatient clinic triage criteria to prioritise referrals

- Main focus is children with chronic symptoms or disease needing specialist review, including:
- (i) hospital-discharged patients,
- (ii) those with uncontrolled physical symptoms or ‘red flag’ signs,
- (iii) complex case management issues and
- (iv) high-risk vulnerable children

Pre-referral Management

- High-quality referral depends not only on the referral itself, but on what happens in primary care before the referral.
- Specialists stress the importance of ‘working up’ the patient in primary care, performing relevant tests, examinations and risk assessments prior to referral (Chew-Graham et al 2007; Bowling and Redfern 2000)
- It is important that, as well as performing necessary tests and investigations, GPs are able to interpret the information gathered correctly. There is some evidence to suggest that poor information gathering, or misinterpretation of the information gathered, is a common cause of inappropriate referral (Jenkins 1993).

RCH Melbourne- Pre referral guidelines

- https://www.rch.org.au/kidsconnect/prereferral_guidelines/

RCH Pre-referral guideline example: Behavioural problems in children

Behaviour or emotional problems

This pre-referral guideline covers behavioural or emotional problems in children from 0 -18 years of age.

Initial work-up

History

- Standard history and physical exam. Include history from parents/ caregivers regarding onset and course of symptoms and family history of similar problems.
- Consider both internalising and externalising behaviour problems, parenting skills, parental mental health, social factors, family dysfunction (e.g.abuse) school problems.Consider possibility of co-morbidities e.g. learning disabilities, developmental disorders.
- Consider administration of: PEDS Screening Tool
- If concerned about psychosis refer urgently to RCH Mental Health Services: Western CAMHS 1800-445511,or Southern Health tel 9594 1300or other regional CAMHS (Child & Adolescent Mental Health Service).

When to refer

- Significant parent concern PEDS Screening Tool
- Problem difficult to define.
- Response to simple behavioural measures not effective.
- Medication may be considered.
- Has co-morbid symptoms that require special assessment or interventions.
- **If suicidal or danger of self harm refer to Emergency Department or call the Crisis Assessment Team.**

Information needed

- Demographic data.
- Birth, developmental and medical history.
- Family and social history.
- Copies of previous mental health, language, cognitive, audiology assessments.
- Treatments: recommended and delivered.
- Response to treatment.
- Information regarding previous medication interventions.

For behavioural/developmental referrals

- School report/letter from school teacher outlining concerns
- Report from day care/preschool- play/social skills/developmental milestones/any concerns/interventions offered
- School counsellor assessment/report
- Vision/Hearing assessment
- Parenting programs/Psychology intervention for behaviour
- Speech/Occupational therapy/Early intervention playgroups

When to refer-Behaviour problems

- Significant parent concern-use of screening Tool
- Problem difficult to define.
- Response to simple behavioural measures not effective.
- Medication may be considered.
- Has co-morbid symptoms that require special assessment or interventions.
- **Letter from school/day-care together with GP referral**

Asthma-Initial work up

- History of allergic disease (e.g. atopic eczema/allergic rhinitis).
- Family history of allergic disease.
- History of asthma symptoms:
- Severity and pattern - infrequent episodic, frequent episodic, persistent.
- Worsening symptoms in pollen season (e.g. October to February).
- Symptoms at night or early morning (e.g. house dust mite).
- Physical examination.
- Concurrent allergic rhinitis?

Asthma- Information needed

- Symptoms (including onset, duration and pattern).
- Treatment given and patient response.
- RAST test result.(aeroallergen- dust mite, grass pollen etc)
- Presence or absence of allergic rhinitis.
- Presence or absence of food allergy.
- Presence or absence of any other allergic disease.

Initial work up- Bed wetting

- Offer treatment 7 years or older.
- Use bladder diary to measure and monitor.
- Explore parenting practices e.g. night fluid restricting, overnight toileting, punitive practices.
- Urine microscopy not required unless separate symptoms indicative of urinary tract infection.
- Assess whether constipation is a problem.

Bed wetting-pre referral treatment

- Night wetting
- Explain causes including genetics.
- Cease night fluid restriction.
- Ensure parents understand that overnight toileting is not curative.
- Treat constipation
- Oral Desmopressin
- Authority for failed alarm treatment and when alarm not suitable (eg school camp)
- Also useful for symptom relief and for short periods (school camp).
- 'Melts' have better bioavailability than tablets.
- Desmopressin nasal spray not recommended (higher risk of hyponatremia).
- NB: Imipramine not recommended (high risk and desmopressin safer alternative).
- Alarm should be re-tried each year.

Constipation- pre referral treatment

- Regular toileting (toilet sits up to 5 minutes, 3 times a day – preferably after meals)
- Behaviour modification diary (record frequency of bowel actions, star charts, rewards).
- Laxative therapy.
- Reassure parents that long term use of laxatives are safe and don't produce a "lazy bowel".
- Encourage a healthy diet and adequate clear fluids.
- Treatment and monitoring often required for months.

When to refer-Constipation

- Constipation is prolonged (>6 months) and treatment resistant.
- Constipation is associated with soiling / wetting.
- Concern regarding underlying organic cause (Hirschsprung disease or anorectal malformation).

Information needed in the referral

- History of onset, frequency of stools, and stool consistency.
- Associated history of soiling, wetting.
- Developmental history, toilet training history.
- Associated behaviour patterns (toilet refusal or withholding behaviours).
- Dietary history (rarely the main cause).
- Physical exam including spine, abdomen and perineal, perianal area.
- Rectal examination is NOT routinely recommended.
- Abdominal x-ray rarely changes management and is NOT recommended.

Key Message

- Using pre-referral guidelines, such as those provided by RCH Melbourne and use of Healthpathways may improve the quality of referrals and triage process.
- Use of RCH pre-referral management guideline can help child receive timely care by primary care professional.
- Healthpathways will be very useful for primary care professionals based on experience elsewhere !

Questions?

- Thank you !