

Monash Children's Hospital

Referral Guidelines

GENERAL PAEDIATRICS

EXCLUSIONS

Conditions not managed by General Paediatrics Services

- Skin prick testing and allergies: refer to [Immunology and Allergy](#)
- Multidisciplinary Autism or Educational assessments: refer to [Developmental Paediatrics](#) (Paediatrician/child psychologist referral required)
- Psychology or speech autism specific assessments: refer to [Developmental Paediatrics](#) (Paediatrician/child psychologist referral required)
- Sleep studies: refer to [Melbourne Children's Sleep Centre](#)
- Metabolic conditions: refer to [Endocrinology and Diabetes](#)
- Obesity: refer to [Paediatric Endocrinology Nutrition clinic](#)
- Patients over 13 years of age: [Click here](#) for relevant adult Monash Health guidelines
- Bell Pad Alarm hire for nocturnal enuresis
- NB: General Paediatric clinics are not multidisciplinary

CONDITIONS

DEVELOPMENTAL CONCERNS

[Developmental delay](#)
[Challenging behaviour](#)
[Learning difficulties](#)

CONTINENCE ISSUES

[Encopresis / soiling](#)
[Enuresis / wetting](#)

GROWTH CONCERNS

[Failure to thrive](#)
[Feeding difficulties](#)

NEONATAL FOLLOW UP

[Preterm Babies](#)
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OTHER GENERAL PAEDIATRIC ISSUES

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[Sleep](#)
[UTI](#)
[First Seizure](#)

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Program Director:
Prof Nick Freezer

Last updated:
03/06/2019



Monash Children's Hospital

Referral Guidelines

GENERAL PAEDIATRICS

PRIORITY

All referrals received are triaged by **Monash Children's Hospital clinicians** to determine **urgency of referral**.

EMERGENCY

For emergency cases please do any of the following:

- send the patient to the Emergency Department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

How to refer to Monash Children's Hospital

Mandatory referral content

Demographic:

Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Interpreter requirements

Clinical:

Reason for referral
Duration of symptoms
Management to date and response to treatment
Past medical history
Current medications and medication history if relevant
Functional status
Psychosocial history
Dietary status
Family history
Diagnostics as per referral guidelines



[Click here](#) to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss clinically urgent referrals contact:
On-call paediatric endocrinologist
via Monash Health main switchboard
(03) 9594 6666

Submit a referral

Fax referral form to Monash Children's Hospital Specialist Consulting Services:
Fax: (03) 8572 3007
Email: scmonashchildrens@monashhealth.org

General enquiries

Phone: (03) 8572 3004

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DEVELOPMENTAL CONCERNS

DEVELOPMENTAL DELAY



WHEN TO REFER?

Initial GP Work Up

- Determine which specific domains are delayed eg. gross motor, fine motor, language, or social/emotional
- Refer for hearing/vision testing as part of differential diagnosis and comorbidities (e.g. vision, hearing, autism spectrum, behaviour problems)
- Standard history and physical exam. Include history from parents /caregivers regarding onset and course of symptoms and family history of similar patterns
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral
- If referring with significant developmental concerns please consider basic work up e.g. TFT's, iron studies, FBE,UEC, CMP, LFT and include all results with referral letter

Management Options for GP

- Refer to allied health professional for an assessment and/or intervention and review within a pre-determined period of time (eg. 3-6 months)
 - E.g. refer for speech pathology assessment in the case of speech and language difficulties
- Refer for Early Childhood Intervention Services if delays identified in 2 or more domains
- Consider eligibility for NDIS

Urgent

Significant developmental regression is a concern and should be referred urgently

Routine

If ongoing concerns about development without known risk factors and after other factors (such as hearing assessment) have been taken into account

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DEVELOPMENTAL CONCERNS (cont'd)

CHALLENGING BEHAVIOUR

WHEN TO REFER?

Initial GP Work Up

- 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, and family dysfunction (e.g. abuse) or school problems. Consider possibility of comorbidities e.g. learning disabilities, developmental disorders
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options for GP

- If the behaviour problems are relatively simple, the GP may consider parental education and behaviour modification strategies with review within a pre-determined period of time (e.g. 3 months) to assess progress
- If the challenging behaviour appears to be specific the GP may consider a referral to a child psychologist for a prescribed course of intervention using a Mental Health Care Plan
- Referral to Early in Life Mental Health Services if there is a strong component of mental health concerns to the presentation

Urgent

Acute unexplained behavioural disturbance may have an underlying neurological cause

Routine

- Significant parent concern
- 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

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DEVELOPMENTAL CONCERNS (cont'd)

LEARNING DIFFICULTIES

WHEN TO REFER?

Initial GP Work Up

- Standard history and physical exam. Include history from parents/ caregivers regarding onset and course of symptoms and family history of similar patterns
- Hearing and vision assessment
- School history
- Consider contributing causes eg. anxiety, family dysfunction
- Consider co-morbidities e.g. ADHD, other behaviour disorders, language disorders, developmental disorders, intellectual disability
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options for GP

- Request an educational psychology assessment through the school
- Refer for cognitive and/or educational testing if suspect intellectual disabilities or specific learning disability
- Depending on local services available, this may be done through the child's school

Routine

- Significant parental concern (PEDS Screening Tool)
- Child not functioning as expected in school
- Cause of learning problems not clear
- Routine school supports e.g. reading recovery, not effective or not sustained
- Previous assessments not well understood, or integrated into school or homework programs
- Child developing anxiety, low self-esteem

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CONTINENCE ISSUES

ENCOPRESIS / SOILING

WHEN TO REFER?

Initial GP Work Up

- History of onset, course and pattern of soiling
- Associated history of constipation, wetting
- Developmental history, toilet training history
- Associated behaviour patterns
- Parent and child's attitude to problem
- Dietary history (rarely the main cause)
- Physical exam including spine, abdomen and perineal, perianal area
- Rectal examination is not routinely recommended
- Abdominal x-rays are not required for diagnosis, may be useful if treatment resistant
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options for GP

- Explanation/ demystification of faecal retention and soiling minimise blame and shame
- Behaviour modification diary (regular toileting, star charts, rewards)
- Combination stool softener and stimulant laxative or Macrogol laxative (Movicol/OsmoLax)
- Encourage high fibre diet, adequate clear fluids
- Treatment and monitoring often required for months
- Refer to Royal Children's Hospital [Clinical Practice Guidelines - Constipation](#)

Routine

- Soiling is prolonged, treatment resistant
- Associated significant behavioural problems
- Soiling associated with daytime wetting
- Soiling not associated with faecal retention and overflow

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CONTINENCE ISSUES (cont'd)

ENURESIS / WETTING

WHEN TO REFER?

Initial GP Work Up

- Developmental history, toilet training history
- Associated behaviour patterns
- Parent and child's attitude to problem

Night wetting

- Offer treatment 7yrs or older
- Use 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 UTI
- Assess whether constipation is a problem

Day wetting

- Consider overactive bladder, low awareness bladder sensation, poor attention / concentration
- Exclude UTI with urine microscopy
- Consider constipation
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Management Options for GP

- Refer to the [Australian Continence Foundation](#) for GP management

Routine

- Night wetting persistent following failed treatment
- Day wetting persistent after constipation / UTI treated
- Child 7 yrs or older

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GROWTH CONCERNS

FAILURE TO THRIVE

WHEN TO REFER?

Initial GP Work Up

- Plot height/length, weight and head circumference on percentile charts (multiple measurements if available to note trend)
- Assess current oral intake and output
- Screen for any mental health concerns in the parents
- Note any intercurrent illness and relevant past medical history
- Standard history and physical exam. Include history from parents /caregivers regarding onset and course of symptoms and family history of similar patterns
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Urgent

Urgent referral may be required if a child has unexplained weight loss or failure to thrive despite adequate caloric intake

Routine

- If child has crossed two percentile curves.
- If there are known risk factors.
- If there is possible mental illness in parents.
- If there are protective issues.
- If there is parental concern

Management Options for GP

- Provide specific intervention then observe closely over a short period of time and review regularly
- Refer to community paediatric dietitian

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FEEDING DIFFICULTIES

WHEN TO REFER?

Initial GP Work Up

- Plot height/length, weight and head circumference on percentile charts and assess growth progress - provide details of growth trajectory in referral
- Estimate intake vs output
- Consider any intercurrent illness and/or relevant past medical history.
- Screen for mental illness in parents
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral
- Check iron studies and treat iron deficiency which is common (Ferritin <50)

Routine

- If child has crossed two percentile curves.
- If there are known risk factors.
- If there is possible mental illness in parents.
- If there are protective issues.
- If there is parental concern

Management Options for GP

- Refer to Maternal and Child Health nurse for more detailed advice
- Refer to community paediatric dietitian
- Provide specific intervention then observe closely over a short period of time and review regularly

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NEONATAL FOLLOW UP

PRETERM BABIES – LESS THAN 35 WEEKS

WHEN TO REFER?

Initial GP Work Up

- If not already being seen elsewhere, obtain pregnancy and perinatal history of baby and mother and conduct a general physical examination
- Plot growth parameters on appropriate growth chart
- Assess whether developmental concerns exist
- Screen for maternal mental health concerns
- Review follow up plan if reviewed by Paediatric service as newborn

Routine

All babies born earlier than 35 weeks gestation should have Paediatric review at least once (usually post delivery). Arrange follow up if never reviewed before.

Management Options for GP

- Liaise with patient's Maternal and Child Health Nurse
- Address maternal depression/anxiety if present

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TERM BABIES – 37- 40 WEEKS GESTATIONAL AGE

WHEN TO REFER?

Initial GP Work Up

- Check if babies have seen a paediatrician in the neonatal period and refer to same paediatrician for follow up if possible
- Usual newborn general examination including take a history of pregnancy and perinatal difficulties
- Screen for maternal mental health concerns
- Plot growth parameters on appropriate growth chart

Routine

If have any concerns regarding growth, feeding, development or other issues that are not resolving within the expected time frame

Management Options for GP

- Liaise with patient's Maternal and Child Health Nurse
- Address maternal depression/anxiety if present

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OTHER GENERAL PAEDIATRIC ISSUES

ASTHMA

WHEN TO REFER?

Initial GP 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 allergy)
- Physical examination
- Concurrent allergic rhinitis
- Serum specific IgE testing to assess for specific allergy, if the history indicates (e.g. cat dander, dust mite, grass pollen)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Emergency

Acute asthma episodes not responding to standard treatment should be referred to the Emergency Department

Routine

- If no improvement or significant symptoms despite initial management
- Significant parental concern

Management Options for GP

Asthma treatment and management:

- Use standard treatment (preventer and reliever)
- Emphasize correct MDI or dry power inhaler technique
- Asthma Action Plan
- First Aid education

Allergen avoidance:

- Only do dust mite avoidance if serum specific IgE and history strongly indicate perennial rhinitis and dust mite sensitisation
- No evidence exists that dust mite avoidance works and it is expensive. Sprays do not work. Err on the side of under-recommending

Treat allergic rhinitis:

- Allergic rhinitis can exacerbate asthma symptoms

Medications to avoid:

- Aspirin
- Non-steroidal anti-inflammatory medicines
- Beta blockers
- 'Natural' remedies (e.g. Echinacea or royal jelly) that may cause allergic reaction

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OTHER GENERAL PAEDIATRICS ISSUES (cont'd)

SLEEP

WHEN TO REFER?

Initial GP Work Up

- Enquire about lifestyle factors, sleep cycles, disruptions/siblings, snoring and comorbidities e.g. obesity
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Routine

- If no improvement despite initial management
- Significant parental concern

Management Options for GP

- Encourage parents to develop day and night routines for their infant/child to assist with the development of day and night rhythms and the transition to night-time sleeping
- significant sleep difficulties and sleep disordered breathing can be referred to the paediatric sleep clinic at MCH
- Refer to Maternal and Child Health nurse for more detailed advice

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URINARY TRACT INFECTION (UTI)

WHEN TO REFER?

Initial GP Work Up

- Urine culture - clean catch urine
- Renal Ultrasound
- Assess bladder function
- Assess for constipation

Please ensure you have provided all of the above plus:

- Growth records
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral

Routine

- Febrile UTI
- Recurrent afebrile UTI (more than 3 in one year)
- Associated hypertension or can't take blood pressure
- Do not refer if single afebrile UTI over 24months of age with no other findings

Management Options for GP

- Consider role of prophylactic antibiotics.
- Do not arrange a routine VCUG (voiding cystourethrogram)

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OTHER GENERAL PAEDIATRICS ISSUES (cont'd)

FIRST SEIZURE



WHEN TO REFER?

Initial GP Work Up

- Enquire about development, general health, sleep
- Document history of fever or intercurrent illness
- Developmental history (M&CH notes, child care records, PEDS Screening Tool)
- 12 lead ECG to look for arrhythmias.
- Details of all treatments offered and tried
- Copies of other relevant letters should accompany the referral
- Consider referral for EEG for afebrile or focal seizures and seizures in children with developmental concerns

Urgent

Focal seizures may indicate a focal cause and should be referred urgently. Imaging may be required (MRI preferred over CT)

Routine

As per "Management options for GP"

Management Options for GP

- Initiate referral
- Encourage parents keep diary of events and video an event if possible
- Request parents to obtain information from school if concern about absence seizures
- Ensure parents know first aid management of a seizure

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