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 assessments: refer to Developmental Paediatrics (Paediatrician/Child Psychiatrist referral required)
- Sleep studies: refer to Melbourne Children's Sleep Centre
- Endocrine conditions: refer to Endocrinology and Diabetes
- Obesity: refer to Paediatric Endocrinology Nutrition clinic
- Patients over 13 years of age: Click here for relevant Adolescent Medicine 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

Term Babies

OTHER GENERAL PAEDIATRIC ISSUES

Asthma

Sleep

UTI

First Seizure

Iron Deficiency

Head of unit:	Program Director:	Last updated:
Dr Catherine McAdam	Prof Nick Freezer	14/01/2022

Monash Children's Hospital

Monash Children's Hospital Referral Guidelines
GENERAL PAEDIATRICS

CONTACT US

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

General enquiries
Phone: (03) 8572 3004

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

OR
Refer via electronic referral using HealthLink. Details available at https://monashchildrenshospital.org/for-health-professionals/gp-ereferrals/

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 - 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 requirement

Clinical:
- ❑ Reason for referral
- ❑ Duration of symptoms
- ❑ Management to date and response to treatment
- ❑ Past medical history
- ❑ Current and previous medications
- ❑ Functional status
- ❑ Family history
- ❑ Diagnostics as per referral guidelines
- ❑ Clinical red flags according to relevant clinical practice guideline

Psychosocial (identify all that apply):
- ❑ Child protection involvement
- ❑ Out of home care
- ❑ Family violence
- ❑ Significant parental mental health disorder or substance abuse
- ❑ Unstable housing, finances or food security
- ❑ Low health literacy
- ❑ Non-citizen or non-Permanent Resident
- ❑ Asylum seeker or refugee status

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14/01/2022

Monash Children's Hospital

DEVELOPMENTAL CONCERNS

DEVELOPMENTAL DELAY

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

WHEN TO REFER?

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 considered.

BACK

DEVELOPMENTAL CONCERNS (cont'd)

CHALLENGING BEHAVIOUR

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

WHEN TO REFER?

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.

BACK

DEVELOPMENTAL CONCERNS (cont'd)

LEARNING DIFFICULTIES

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

WHEN TO REFER?

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.

BACK

CONTINENCE ISSUES

ENCOPRESIS / SOILING

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

WHEN TO REFER?

Routine

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

BACK

CONTINENCE ISSUES (cont'd)

ENURESIS / WETTING

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

WHEN TO REFER?

Routine

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

BACK

GROWTH CONCERNS

FAILURE TO THRIVE

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

Management Options for GP

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

WHEN TO REFER?

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.

BACK

FEEDING DIFFICULTIES

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)

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

WHEN TO REFER?

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

BACK

NEONATAL FOLLOW UP

PRETERM BABIES – LESS THAN 35 WEEKS

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

Management Options for GP

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

WHEN TO REFER?

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.

BACK

TERM BABIES – 37- 40 WEEKS GESTATIONAL AGE

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

Management Options for GP

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

WHEN TO REFER?

Routine

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

BACK

OTHER GENERAL PAEDIATRIC ISSUES

ASTHMA

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

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

WHEN TO REFER?

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.

BACK

OTHER GENERAL PAEDIATRICS ISSUES (cont'd)

SLEEP

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

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

WHEN TO REFER?

Routine

- If no improvement despite initial management.
- Significant parental concern.

BACK

URINARY TRACT INFECTION (UTI)

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

Management Options for GP

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

WHEN TO REFER?

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.

BACK

OTHER GENERAL PAEDIATRICS ISSUES (cont'd)

FIRST SEIZURE

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

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

WHEN TO REFER?

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".

BACK

IRON DEFICIENCY

Iron deficiency of **known aetiology** - oral supplementation is the preferred option. If patient will not take oral supplementation, refer to General Paediatric clinic (<13 years of age) or Adolescent Medicine clinic (13 – 18 years of age) for consideration of iron infusion.

Iron deficiency of **unknown origin**, or failure to respond to appropriate oral or IV supplementation can be referred to Paediatric Haematology.

Initial GP Work Up

General

- Full Blood Examination (FBE)

Iron Deficiency

- FBE, iron studies, CRP, UEC, LFT, B12, folate, reticulocytes
- Coeliac serology if there is a history that warrants; slowing growth, abdominal pain, diarrhoea.

Management Options for GP

- Trial of oral iron for at least 3 months
- Dietary history and guidance re appropriate iron intake
- Faecal occult blood screen

WHEN TO REFER?

Urgent

Anaemic with minimal abnormal signs.

Routine

Stable child, known iron deficiency.

BACK