Clinical Prioritisation Criteria

Respiratory and Sleep Medicine CPC v0.11

Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for Respiratory and Sleep Medicine (adult). It is a consultation document only. This is a drafting document and should be read in conjunction with the consultation overview.

The final format will be as indicated on the CPC website https://cpc.health.qld.gov.au/ and embedded into your local HealthPathways site or HHS site i.e. 'Refer your patient' website https://metrosouth.health.qld.gov.au/referrals or www.health.qld.gov.au/metronorth/refer.

For more information about the CPC development process and purpose, please see the accompanying CPC Consultation Overview.

Contents

Respiratory and Sleep Medicine inclusion for outpatient services

The following conditions are proposed to be considered under the Respiratory and Sleep Medicine CPC.

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the CPC exclusions section.

- Asthma
- Bronchiectasis / chronic suppurative lung disease
- Chronic cough
- Chronic obstructive pulmonary disease
- Cystic fibrosis
- Haemoptysis without known lung disease
- Interstitial lung disease (ILD)
- Lung cancer
- Pleural disorders
- Pulmonary hypertension
- Recurrent respiratory infections without known lung disease
- Sarcoidosis
- Shortness of breath / dyspnoea without a known cause
- Sleep disordered breathing (suspected or confirmed)
- Sleep disorders excluding sleep disordered breathing
- Tuberculosis / non-tuberculosis mycobacterial infections

Respiratory and Sleep Medicine paediatric conditions

The following paediatric conditions are to be considered under the Respiratory and Sleep Medicine CPC. Alternatively, please consider if it is necessary to develop a separate paediatric CPC for Respiratory and Sleep Medicine.

- Paediatric respiratory and sleep medicine conditions to be developed at a later date

Respiratory and Sleep Medicine exclusions for outpatient services

Not all services are appropriate to be seen in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Respiratory and Sleep Medicine service

The following are not routinely provided in a public Respiratory and Sleep Medicine service

- Chest wall pain
- Non-cardiac chest pain
- Occupational lung assessment
- Direct screening TB – should be referred to contact and immigration screening (TB control centre)

Referral and outpatient criteria

Asthma

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute exacerbation of asthma not responding to therapy
- Asthma with any of the following concerning features:
  - coexistent pneumothorax
  - pneumonia
  - silent chest
  - cardiovascular compromise
  - altered consciousness
  - relative bradycardia
  - decreasing rate and depth of breathing

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• History of life threatening asthma in the past 12 months requiring ventilation or ICU admission • Unstable asthma with consistent FEV1 < 60% predicted • Asthma caused or exacerbated by workplace exposure where patient is unable to work as a result
Category 2 (appointment within 90 calendar days)	• Inadequate asthma control as defined in *Other useful information* despite optimal treatment: • Asthma related hospital admission/s in the last 3 months • Need for oral corticosteroids on more than 1 occasion in the last year • Asthma with frequent after-hours attendance (ED or after-hours GP) despite optimal treatment • Asthma caused or exacerbated by workplace exposure where patient is still able to work as a result
Category 3 (appointment within 365 calendar days)	• Uncertainty about diagnosis • Asthma education where this cannot be provided in primary care • Stable asthma requiring respiratory specialist opinion

Reason for request, indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

Essential referral information, Referral will be rejected without this

- Approximate age at diagnosis
- Duration and severity of symptoms (breathlessness, chest tightness, wheezing and cough)
- Frequency of exacerbations
- Management including:
  - current medications (including complete list of all patient's medications)
  - previously tried respiratory medications
- Oral prednisolone use
- Previous hospitalisations
- Allergies
- Spirometry (if available)

Additional referral information, Useful for processing the referral

- Allergy testing results
- Triggers
- Assessment of adherence to treatment
- Smoking status
- Family history of asthma
- FBC results
- CXR
- Comorbid conditions

Request

> General referral information/Standard information (Appendix 2, Consultation overview)

> Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating, or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

Other useful information for referring practitioners, not an exhaustive list

The aim of asthma management is to control the disease. Complete control is defined as:

- No day or night symptoms
- Minimal or no need for beta agonist treatment (less than 2-3 times per week)
- No exacerbations
- No limitations on physical activity
- Minimal side effects of treatment

Clinical resources (links)	Patient resources (links)

• National Asthma Council Australia including **Asthma Action Plans** https://www.nationalasthma.org.au/health-professionals/asthma-action-plans • National Asthma Campaign (NAC) literature http://trove.nla.gov.au/people/540307?c=people • Thoracic Society of Australia & New Zealand guidelines http://www.thoracic.org.au/professional-information/position- papers-guidelines/asthma/ • Australian Asthma Handbook http://www.asthmahandbook.org.au/	• Asthma Australia http://www.asthmaaustralia.org.au • National Asthma Council Australia http://www.nationalasthma.org.au/

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Bronchiectasis / chronic suppurative lung disease

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Bronchiectasis / CSLD with any of the following concerning features:
  - Altered consciousness
  - Hypoxia (<90% oxygen saturation) when this is not normal for the patient
  - New haemoptysis (clots or more than streaks)
  - New CXR changes indicative of cavitation, consolidation or pneumonia

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Chronic bronchiectasis / CSLD with recurrent haemoptysis
Category 2 (appointment within 90 calendar days)	• Chronic bronchiectasis / CSLD with frequent (>3 per year) infective exacerbations despite optimal therapy • Stable symptomatic chronic bronchiectasis / CSLD
Category 3 (appointment within 365 calendar days)	• Asymptomatic newly diagnosed or suspected bronchiectasis / CSLD

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- History of the disease including duration, severity and frequency of exacerbations
- Management to date
- Medications including previously tried medications if associated with treatment failure or problems
- Results of previous sputum cultures
- Results of previous chest CT (not during an exacerbation)

Additional referral information, Useful for processing the referral

- History of childhood respiratory infections (eg Whooping cough)
- Family history of cystic fibrosis
- Presence of cor pulmonale or sinus disease
- FBC, ESR, Immunoglobulins with IgG sub class results
- CXR
- Spirometry

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not a comprehensive list

- Ongoing treatment requires regular and coordinated primary health care and specialist review, including monitoring for complications and comorbidities. Chest physiotherapy and regular exercise should be encouraged, nutrition optimised, environmental pollutants (including tobacco smoke) avoided, and vaccines administered according to national immunisation schedules.

Clinical resources (links)	Patient resources (links)
• A position statement from the Thoracic Society of Australia and New Zealand and the Australian Lung Foundation on CSPD and Bronchiectasis • AFP article on bronchiectasis in primary care • Management of bronchiectasis and CSPD in indigenous children and adults in remote and rural Australian communities • European Respiratory Society guidelines for the management of adult bronchiectasis	• http://bronchiectasis.com.au/resources/other-resources/patient-handouts

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- See first listed CPC condition for details

Chronic cough

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- No referral to emergency criteria

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• Cough present for > 8 weeks with normal CXR and normal spirometry and no improvement following treatment trial as specified in *Other useful information*

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Symptoms
  - Duration and severity
    - Associated syncope, incontinence, SOB
- Relevant examination findings
  - History of ENT problems
  - Check uniform lung expansion and any percussive changes
- Medications including results of treatment trial as per defined in Other useful information
- FBC, ELFT and ESR results
- CXR

Additional referral information, Useful for processing the referral

- Symptoms including:
  - any diurnal variation in severity (e.g. nocturnal or positional)
  - triggers e.g. air temp, food, talking, exercise
  - swallowing difficulties
  - voice change
- High resolution chest CT (if already performed)
- Spirometry pre and post bronchodilator
- Smoking and occupational history if relevant
- Previous gastroscopy findings

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- There are many causes of persistent cough. These can be categorised into:
  - respiratory
  - ENT (PN drip)
  - gastrointestinal
  - drug related (ACEI, aspirin, beta blockers)
  - cardiac (heart failure)

Treatment trial:

Ensure occult sino-nasal disease, unresolved infectious bronchitis and acid reflux have been considered and treated appropriately. ACE inhibitors should be ceased and an alternate medication substituted (e.g. angiotensin 2 receptor antagonists).

1. Four-week trial of PPI
2. If unsuccessful, or symptoms of PN drip, commence a six-week trial of intra nasal steroid
3. If unsuccessful, or evidence of asthma, commence a four-week trial of inhaled steroids
4. If unsuccessful, complete CT chest scan (including high resolution images) and refer to specialist.

Clinical resources (links)	Patient resources (links)
• New England Journal of Medicine – Chronic Cough article	

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Chronic obstructive pulmonary disease

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute exacerbation not responding to outpatient therapy
- Acute respiratory failure

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• COPD with chronic respiratory failure • COPD with worsening right heart failure
Category 2 (appointment within 90 calendar days)	• Recurrent (>3 in 12 months) acute exacerbations or acute presentations to emergency • Uncontrolled symptoms on daily basis that limit ADLs • Requiring assessment for oxygen therapy • COPD with demonstrated severe airflow obstruction (FEV1 <35%)
Category 3 (appointment within 365 calendar days)	• Stable COPD for consideration for pulmonary rehabilitation or education (where community services are not available)

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Duration and severity of symptoms including impact on ADLs
- Current and previous treatment and efficacy
- Comorbidities
- Smoking / occupational history
- Spirometry (if available)
- CXR (within last 12 months)

Additional referral information, Useful for processing the referral

- History of childhood/adolescent lung disease
- SaO_2 or ABG
- Vaccination status
- FBC, Chem20 results
- Respiratory function tests
- Exercise oximetry

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

Clinical resources (links)	Patient resources (links)
• Australia and New Zealand Guidelines for the management of COPD (COPD-X) • COPD value pyramid	• Lung foundation COPD resources

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Cystic fibrosis

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Cystic fibrosis with any of the following concerning features:
  - respiratory distress
  - new haemoptysis (clots or more than streaks)
  - pleural effusion
  - consolidation/pneumonia/fever
  - non- response to antibiotics for chest infection

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Newly diagnosed cystic fibrosis • Patients with known cystic fibrosis transitioning from a paediatric or other adult centre who have recent clinical instability and/or severe lung disease (FEV1<40%)

Category 2 (appointment within 90 calendar days)	• Suspected but undiagnosed cystic fibrosis • Patients with known cystic fibrosis transitioning from a paediatric or other adult centre who have recent clinical stability or moderate lung disease (FEV1>40%)
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Medications
- Symptoms including:
  - duration
  - severity
  - non- pulmonary CF problems
  - recent admissions
- Previous centre of care (if transitioning patient)

Additional referral information, Useful for processing the referral

- Calcium, vitamin D, coagulation profile, fasting glucose, fat soluble vitamin levels and iron study results
- Spirometry
- Family history
- FBC, ELFT results
- CXR/CT and any other relevant imaging
- Any recent sputum culture results
- Genotype
- Weight history/trend

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

Clinical resources (links)	Patient resources (links)
• Standards of Care for Cystic Fibrosis in Australia 2008 www.thoracic.org.au	• Cystic Fibrosis Australia • Cystic Fibrosis Queensland (via above website)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Haemoptysis without known lung disease

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Significant haemoptysis defined as repeated expectoration of 5mL (1tsp) of blood or single episode of >20mL (1tbsp)
- Any haemoptysis with acute dyspnoea, measured hypoxia, altered consciousness, hypotension, tachycardia or chest pain

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Recurrent low volume haemoptysis on a daily basis over three days • Intermittent low volume haemoptysis over three-week period
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Comorbidities
- Medication list (particularly anticoagulants)
- Recent clinical events (particularly viral symptoms, infective bronchitis)
- FBC, Chem20, coagulation screen results
- CXR

Additional referral information, Useful for processing the referral

- CT scan - thorax +/- sinuses (if available)
- INR results if on warfarin
- Previous lung function test results (if available)

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

•

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Interstitial lung disease (ILD)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute exacerbations of known ILD with any of the following concerning features:
  - severely breathless/Class 4 dyspnoea (ADL's affected by dyspnoea)
  - demonstrated worsening hypoxaemia
  - new arrhythmia/chest pain
- Newly diagnosed or suspected ILD with radiographic evidence with Class 4 dyspnoea (ADLs affected by dyspnoea)

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Newly diagnosed or suspected ILD with Class 2/3 dyspnoea • Known ILD with worsening hypoxemia or right heart failure
Category 2 (appointment within 90 calendar days)	• Chronic ILD with Class 1 dyspnoea • Newly diagnosed or suspected ILD without symptoms
Category 3 (appointment within 365 calendar days)	• Known ILD with stable symptoms requiring specialist opinion

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Duration and severity of ILD or symptoms
- Management to date
- Other relevant medical conditions (particularly connective tissue disorders)
- Medications
- Occupational history
- CXR
- High resolution CT (HRCT) chest

Additional referral information, Useful for processing the referral

- Previous lung function
- FBC, auto-antibody screen results (if available)

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

•

Clinical resources (links)	Patient resources (links)
• Modified Medical Research Council (mMRC) Dyspnoea Scale	• Lung foundation

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- See first listed CPC condition for details

Lung cancer

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Suspected or known lung cancer with any of the following concerning features:
  - massive haemoptysis
  - suspected large airway obstruction
  - severe dyspnoea
  - SVC obstruction
  - hypercalcaemia/hyponatremia with confusion
  - symptomatic pleural effusion

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspected lung cancer • Previously treated lung cancer with suspected recurrence
Category 2 (appointment within 90 calendar days)	• No category 2 criteria
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Past medical history
- Current medications
- Previous cancer history including non-lung cancer treatment
- Relevant **imaging** (CXR/CT) (including previous **images**)

Additional referral information, Useful for processing the referral

- Smoking history
- Occupational history
- FBC, ELFTs and any other relevant pathology results
- Pathology results of previous cancer

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- Please ensure patients bring radiology images to appointments

Clinical resources (links)	Patient resources (links)
• Investigating symptoms of lung cancer. A guide for GP's • Optimal care pathway for people with lung cancer • Quick reference guide	• Lung foundation

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Pleural disorders

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Large symptomatic pleural effusion
- Acute pneumothorax

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Pleural effusion
Category 2 (appointment within 90 calendar days)	• Extensive pleural disease ie pleural thickening, pleural calcification
Category 3 (appointment within 365 calendar days)	• Pleural plaques

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- History of symptoms
- Smoking history
- History of occupational exposure (eg asbestos) or TB exposure
- Cardiac history
- History of previous malignancy
- Relevant imaging

Additional referral information, Useful for processing the referral

- FBC, ELFTs, coagulation study results
- Medications
- Echocardiogram (if available)
- VQ scan (if available)

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

-

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient
See first listed CPC condition for details

Pulmonary hypertension

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute decompensation (hypoxia or right heart failure) with pulmonary hypertension

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Newly diagnosed pulmonary hypertension without known heart or lung disease • Known pulmonary hypertension with Class 3/4 dyspnoea (ADLs affected by dyspnoea) • Known pulmonary hypertension with deteriorating functional status over 3 months
Category 2 (appointment within 90 calendar days)	• Known pulmonary hypertension with deteriorating functional status over the past year • Known pulmonary hypertension with Class 1/2 dyspnoea
Category 3 (appointment within 365 calendar days)	• Stable pulmonary hypertension for specialist opinion

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Details of any previous:
  - cardiac disease
  - respiratory disease
  - venous thromboembolism
- Degree of functional impairment
- Known history of connective tissue disorders
- Medication history
- Relevant imaging (CT thorax, CTPA, V/Q scan, echo)

Additional referral information, Useful for processing the referral

- RBC, Chem20, ANF, ENA results
- Lung function (if available)
- Family history
- Sleep investigations

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

•

Clinical resources (links)	**Patient resources (links)**

• Modified Medical Research Council (mMRC) Dyspnoea Scale	

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Recurrent respiratory infections without known lung disease

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- No referral to emergency criteria

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• More than 3-4 presentations of lower respiratory infections requiring antibiotics in the past 12 months
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Description of lower respiratory tract symptoms with supporting investigations e.g. CXR, sputum culture, WCC

Additional referral information, Useful for processing the referral

- Details of antibiotics previously prescribed for respiratory tract infections

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- Please consider that most adults with recurrent lower respiratory infection will have COPD, bronchiectasis or aspiration.

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Sarcoidosis

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Hypercalcaemia with acute kidney injury

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Known or suspected sarcoidosis with any of the following concerning features: – visual disturbance – hypercalcemia – palpitations – pre- syncope – Class 3/4 dyspnoea (ADLs affected by dyspnoea)
Category 2 (appointment within 90 calendar days)	• Known sarcoidosis with progressive symptoms • Suspected sarcoidosis
Category 3 (appointment within 365 calendar days)	• Known sarcoidosis requiring specialist review

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Details of symptoms including duration and severity
- CXR and/or CT scan

Additional referral information, Useful for processing the referral

- Sputum culture (including TB culture)
- FBC, ELFT, ESR, ACE level, calcium level results
- Lung function and gas transfer studies (if available)

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

Clinical resources (links)	Patient resources (links)
• Modified Medical Research Council (mMRC) Dyspnoea Scale	• Sarcoidosis association

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Shortness of breath / dyspnoea without a known cause

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Dyspnoea of uncertain origin with any of the following concerning features:
  - acute dyspnoea at rest
  - demonstrated hypoxia (SpO2 < 88%)
  - accompanied by confusion

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Class 4 dyspnoea (ADLs affected by dyspnoea) • Oxygen saturation 88-92% at rest
Category 2 (appointment within 90 calendar days)	• Unexplained chronic dyspnoea of uncertain origin
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Details and timeline of symptoms including variability and severity
- Relevant medical conditions
- Smoking and occupational history if relevant

Additional referral information, Useful for processing the referral

- FBC, ELFT, ESR, TFT results
- Lung function pre and post bronchodilator
- ECG
- CXR
- Sputum M/C/S if productive cough
- Other relevant imaging
- Pulse oximetry

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

There are many causes of shortness of breath. These can be categorised into:

- respiratory (Infective, related to chronic lung disease (COPD, bronchiectasis, restrictive LD, occupational LD, asthma, TB), cancer, foreign body, allergic, sarcoid)
- cardiac (heart failure, ischaemic heart disease, valvular heart disease, arrhythmias, pulmonary HT)
- vascular (pulmonary emboli, infarction)
- ENT/endocrine related (laryngeal obstruction, thyroid enlargement causing tracheal compression, thyrotoxicosis)
- gastrointestinal (GORD, tracheo-oesophageal fistula, aspiration)
- haematological (anaemia, leukaemias)
- neurological/neuromuscular (degenerative (MS, MND, myasthenia gravis, Guillian-Barre syndrome)
- psychogenic (anxiety)
- chronic debility or obesity related
- drug related

It is important to at least arrive at a probable diagnosis as this will determine which specialty to refer. It should be possible to arrive at a diagnosis in most cases by careful history and examination with directed investigations.

Clinical resources (links)	Patient resources (links)
• BMJ step by step diagnostic plan for breathlessness • BMJ best practice differential diagnosis of breathlessness • Modified Medical Research Council (mMRC) Dyspnoea Scale	

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Sleep disordered breathing (suspected or confirmed)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- No referral to emergency criteria

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspected or confirmed sleep apnoea with any of the following: – Epworth Sleepiness Scale score ≥16 – dozing while driving at least 1-2/month – MVA or work-related accident related to sleepiness/inattention in last 12 months – unstable cardiovascular disease eg overt heart failure • Suspected or confirmed sleep hypoventilation with any of the following: – progressive neuromuscular disorder – established daytime hypercapnia (as demonstrated on ABG (if performed)) – diagnostic sleep study demonstrating mean sleep saturation 85-90% (Mean sleep saturation <85% should ideally be seen within 2 weeks)

Category 2 (appointment within 90 calendar days)	• Suspected or confirmed sleep apnoea with any of the following: – Epworth Sleepiness Scale score 12-15 – dozing while driving in last 12 months – MVA or work-related accident related to sleepiness/inattention in last 5 years – occupation involving driving / heavy machinery operation – significant comorbidities for example pulmonary hypertension, previous stroke, heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism – Respiratory Disturbance Index of ≥30 respiratory events per hour on a diagnostic sleep study
Category 3 (appointment within 365 calendar days)	• Suspected or confirmed sleep apnoea that do not meet criteria for Category 1 or 2 but still require specialist review.

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- History of sleep disorder including duration and severity of symptoms, snoring, witnessed apnoeas, restless sleep, unrefreshing sleep, tiredness, inappropriate falling asleep
- Management to date including any previously tried appliances (mandibular advancement splint, CPAP) and response
- Current medications
- Epworth Sleepiness Scale score
- OSA-50 or STOP Bang questionnaire results
- Full report from all previous sleep studies
- Occupation
- Driving licence type
- History of motor vehicle accidents or sleepiness/inattention when driving

Additional referral information, Useful for processing the referral

-

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- Referring doctor must assess immediate risk of driving and provide appropriate counselling based on Assessing Fitness to Drive Guidelines (including avoiding driving altogether if necessary).

Clinical resources (links)	Patient resources (links)
• Australasian sleep association • Queensland Government - Assessing fitness to drive • National institutes of health information site • Health Direct Australia Government website with many trusted information links	• Sleep health foundation

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Sleep disorders excluding sleep disordered breathing

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- No referral to emergency criteria

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Unexplained hypersomnolence (Epworth Sleepiness Scale score ≥ 16) not attributed to inadequate sleep hygiene or environmental factors
Category 2 (appointment within 90 calendar days)	• Suspected or confirmed narcolepsy • Suspected or confirmed parasomnia or nocturnal seizures with injury to self or others • Suspected or confirmed sleep related movement disorder with injury to self or others • Unexplained hypersomnolence (Epworth Sleepiness Scale score ≥ 12) not attributed to inadequate sleep hygiene or environmental factors
Category 3 (appointment within 365 calendar days)	• Suspected or confirmed sleep disorders (other than sleep apnoea) that do not meet criteria for Category 1 or 2 but still require specialist review.

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- History of sleep disorder including frequency, duration and severity of symptoms
- Management to date and efficacy
- Current medications
- Epworth Sleepiness Scale score
- Full report from all previous sleep studies

Additional referral information, Useful for processing the referral

-

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- Referring doctor must assess immediate risk of driving and provide appropriate counselling based on Assessing Fitness to Drive Guidelines (including avoiding driving altogether if necessary).

Clinical resources (links)	Patient resources (links)
• Australasian sleep association • Queensland Government - Assessing fitness to drive • National institutes of health information site • Health Direct Australia Government website with many trusted information links	• Sleep health foundation

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

Tuberculosis / non-tuberculosis mycobacterial infections

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Suspected tuberculosis with significant haemoptysis (defined as repeated expectoration of 5mL (1tsp) of blood or single episode of >20mL (1tbsp)

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspected or proven pulmonary or extrapulmonary tuberculosis • Suspected non-tuberculosis mycobacterial infection with cavitary lung disease or significant haemoptysis
Category 2 (appointment within 90 calendar days)	• Suspected pulmonary non-tuberculosis mycobacterial infection
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Reason for request, indicate on the referral

See first listed CPC condition for details

Essential referral information, Referral will be rejected without this

- Duration and severity of symptoms including dyspnoea, cough, chest pain, weight loss, night sweats, systemic symptoms
- History of chronic lung disease
- Travel history / immigrant status
- Known contact with tuberculosis
- History of HIV/AIDS or other immunosuppression
- CXR
- FBC, ELFT results
- Sputum culture results

Additional referral information, Useful for processing the referral

- Chest CT (if available)

Request

See first listed CPC condition for details

Other useful information for referring practitioners, not an exhaustive list

- Contact details for your local tuberculosis service can be found on the Queensland Health website: Contact a tuberculosis service webpage.

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

See first listed CPC condition for details

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Version control

Version	Date	Author	Nature of amendment
0.01	17/11/17	CPC team (Katie Wykes)	Initial draft
0.02	14/2/18	CPC team (Katie Wykes)	Change of template
0.03	22/02/18	CPC team (Katie Wykes)	Amendments to COPD and Pulmonary HTN following discussion with CL
0.04	2/3/18	CPC team	Amendments to list of conditions and to Asthma condition following CAG meeting
0.05	28/3/18	CPC Team and CAG	Amendments following CAG meeting.
0.06	18/4/18	CPC Team and CAG	Amendments following CAG meeting and removal of paeds conditions as they will be developed separately
0.07	6/6/18	CPC Team and CAG	Amendments following CAG meeting.
0.08	19/6/18	CPC team	Addition of bibliography
0.09	7/8/18	CPC team	Amendments to sleep conditions
0.10	7/9/18	CPC team	Amendments following CL review of GP feedback
0.11	25/9/18	CPC team	New template