Consultation overview

Clinical Prioritisation Criteria for Cardiology

December 2017

This document should be read in conjunction with the draft Clinical Prioritisation Criteria

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Consultation overview: CPC for Cardiology

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Purpose

This consultation overview has been prepared to accompany the draft Clinical Prioritisation Criteria (CPC) for cardiology and provide a useful overview during the CPC development and consultation process.

Introduction

CPC are clinical decision support tools that will help ensure Queensland patients are assessed in order of clinical urgency. They will be used by both referring practitioners when referring patients to specialist outpatient services and specialist outpatient services when determining how quickly the patient should be seen (urgency category).

CPC have been developed to improve the patients’ specialist outpatient experience. CPC aim to support:

- equitable assessment of patients regardless of geographical location within Queensland
- the provision of specialist outpatient appointments in order of clinical urgency
- ensuring patients are ready for care at their first specialist outpatient appointment
- improved referral and communication processes between referrers and specialists outpatient services.

Importantly, CPC will assist rather than replace clinical judgment and decision making.

CPC will integrate into local care pathways, or HealthPathways so that GPs and other referring practitioners and their patients can be sure that referral to a public medical specialist service is appropriate, regardless of whether that specialist service is available in their local area.

The implementation of CPC may mean that some patients will be offered appropriate care in a different setting or appropriate care with an alternative health care provider (for example allied health or nurse led clinics) rather than waiting to be offered a specialist outpatient appointment.

CPC development

Clinical Advisory Groups (CAGs) are utilised for each specialty area. Guided by a clinical lead, the CAGs provide expert clinical advice to inform the development of the relevant CPC. This is important to ensure the criteria are clinically relevant and credible.

CAG membership includes general practitioners (GPs), medical specialists, nurses and allied health professionals. A list of current CAG participants for cardiology is listed in Appendix 1.

The development process can be broadly described in the below diagram. As the CPC progress through the development and consultation process, different groups of stakeholders may be invited to participate.

The content in the attached draft has been drawn from existing guidelines implemented in some Queensland Hospital and Health Services (HHSs), in other Australian jurisdictions or internationally. The draft CPC should be seen as a starting point only with outcomes of the consultation and testing a key input to the final content.

CPC format

The draft CPC attached to this overview is not the final format or layout for the CPC. The CPC will be published to the CPC website (https://cpc.health.qld.gov.au/) and will also be integrated into the HealthPathways platform. Once the CPC has been finalised by the CAG, the website will be the source of all truth.

HealthPathways is a web-based information portal that provides pathways for assessment, management
and referral of patients and assists clinicians to navigate the patient through the complex local health system. HealthPathways is designed to be used at the point of care, primarily for general practitioners, but is also available to specialists, nurses, allied health and other health professionals.

**In scope conditions**
The conditions for which criteria are to be developed are determined by the CAG. This may not be a comprehensive list of all conditions (symptoms, diagnoses) seen by specialists in that area; however, will typically be the most common conditions presenting for first specialist outpatient appointment. Where available this will be informed by data on presenting conditions; however, statewide data for outpatients is not currently able to be interrogated at this level.

Conditions and interventions can be added (or removed) in future reviews and updates of the CPC.

**Paediatric conditions**
Historically in CPC development, the CPC Paediatric Advisory Group (PAG) considered the most common paediatric presentations for each specialty, those conditions where there was potential to receive unnecessary referrals and those conditions where there may be a waiting list to be reviewed in outpatients. This advice was provided to the CAG, and the list of conditions was expanded or reduced in consultation with the PAG. Consideration was also given to whether paediatric conditions (those unique to children) or conditions commonly impacting children could suitably be addressed or included in the draft CPC or warrant development of a specific paediatric CPC for that specialty.

In early 2017, the PAG closed as they had fulfilled their terms of reference. From this point forward all new CPCs developed will include the following clinicians as invited stakeholders so that they may contribute as they see fit:

- members of the now closed PAG
- members of the Statewide Child and Youth Clinical Network.

Each CAG must have a paediatric representative to provide advice from a paediatric perspective.

**Purpose of referral and outpatient criteria**
The information in the draft CPC for cardiology (Attachment 1) is intended to assist:

- GPs and other referring practitioners to identify the point at which a patient may benefit most from a first referral to specialist outpatient services, the information necessary to support the referral, and how quickly the patient may be seen.
- Appropriate HHS staff to make transparent and equitable decisions on when referrals should be accepted and the timeframe for first appointment.

**Consultation questions**
To assist in providing feedback on the draft CPC, please consider the following general questions.

1. Are the criteria clinically appropriate and evidenced-based?
2. Have only the minimum criteria necessary for triaging been included?
3. Is the CPC applicable across the state? i.e. referral into tertiary facilities to rural facilities.
4. Do the criteria adequately and appropriately differentiate triage categories?
5. Is there any other relevant information that should be considered or incorporated into HealthPathways?
Other useful information
In the course of engaging with stakeholders about CPC more information has been sought on a number of topics. This information is provided in the following appendices.

- Appendix 1: Clinical Advisory Group members
- Appendix 2: General referral information
- Appendix 3: Urgency categorisation
- Appendix 4: Named referrals
- Appendix 5: Scope of publicly funded services

How to provide feedback
Feedback on the draft CPC for cardiology will be discussed at Clinical Advisory Group meetings but can be also provided via email to cpc@health.qld.gov.au.

Contact us
Email:   cpc@health.qld.gov.au
Phone:   (07) 3328 9040
Appendix 1 Clinical Advisory Group (CAG)

The following clinicians nominated to participate in the development of the cardiology CPC. Participation was voluntary and members contributed as and when able.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Role ID for CPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/Prof Sudhir Wahi (Clinical Lead)</td>
<td>Director of Echocardiography, Senior Staff Cardiologist at Princess Alexandra Hospital, Metro South HHS A/Prof, University of Queensland President of the Queensland Branch of the Cardiac Society of Australia and NZ</td>
<td>Medical</td>
</tr>
<tr>
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<td>Cardiac Rehabilitation Redesign Project Officer, Redland Hospital, Metro South HHS Senior Physiotherapist, Princess Alexandra Hospital, Metro South HHS</td>
<td>Allied Health</td>
</tr>
<tr>
<td>Jared Bruning</td>
<td>Advanced Physiotherapist, Cardiology, Sunshine Coast University Hospital, Sunshine Coast HHS</td>
<td>Allied Health</td>
</tr>
<tr>
<td>Prof Adam Scott</td>
<td>Adjunct Professor, Queensland University of Technology Director of Cardiac Sciences, Cardiac Investigations Unit, Royal Brisbane and Women’s Hospital, Metro North HHS</td>
<td>Technical (Cardiac Scientist)</td>
</tr>
<tr>
<td>Simon Townsend</td>
<td>Advanced Clinical Measurement Scientist – Cardiac, The Prince Charles Hospital, Metro North HHS</td>
<td>Technical (Cardiac Scientist)</td>
</tr>
<tr>
<td>David Eastgate</td>
<td>Director, Health Equity and Access Unit, Metro South HHS</td>
<td>Other</td>
</tr>
<tr>
<td>Dr Ben Reeves</td>
<td>Paediatric Cardiologist, Cairns Hospital, Cairns &amp; Hinterland HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>Dr Greg Plowman</td>
<td>Staff Specialist, General Medicine, Sunshine Coast HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>A/Prof lan Scott</td>
<td>Director of General Medicine, Princess Alexandra Hospital, Metro South HHS Co-chair, Statewide General Medicine Clinical Network</td>
<td>Medical</td>
</tr>
<tr>
<td>Dr John Hill</td>
<td>Cardiologist, Princess Alexandra Hospital, Metro South HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>A/Prof Karam Kostner</td>
<td>Director of Cardiology, Mater Health Services, South Brisbane, and Associate Professor of Medicine, University of Queensland</td>
<td>Medical</td>
</tr>
<tr>
<td>Dr Raibhan Yadav</td>
<td>Director of Cardiology, Townville Hospital, Townsville HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>Prof Rohan Jayasinghe</td>
<td>Medical Director - Cardiology Department, Gold Coast University Hospital, Gold Coast HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>Dr Stuart Cox</td>
<td>Cardiologist, Sunshine Coast University Hospital, Sunshine Coast HHS</td>
<td>Medical</td>
</tr>
<tr>
<td>Dr Fabian Jaramillo</td>
<td>GP Liaison Officer, Metro North HHS HealthPathways Clinical Editor, Brisbane North PHN</td>
<td>GP</td>
</tr>
<tr>
<td>Dr Jon Harper</td>
<td>GP Liaison Officer, Sunshine Coast HHS Clinical Lead for HealthPathways and CPC Implementation, Sunshine Coast PHN</td>
<td>GP</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Role</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Dr Michael Hamilton</td>
<td>GP Liaison Officer, Brisbane North PHN / Metro North HHS</td>
<td>GP</td>
</tr>
<tr>
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<td>GP, Hervey Bay HealthPathways Clinical Editor, Wide Bay</td>
<td>GP</td>
</tr>
<tr>
<td>Dr Wai-Keung Lee</td>
<td>GP, Townsville HealthPathways Clinical Editor, North Queensland PHN</td>
<td>GP</td>
</tr>
<tr>
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<td>GP</td>
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<td>Nurse</td>
</tr>
<tr>
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<td>Nurse</td>
</tr>
<tr>
<td>Catherine Moore</td>
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<td>Nurse</td>
</tr>
<tr>
<td>Godfrey Martis Ajgaonkar</td>
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<td>Nurse</td>
</tr>
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</tr>
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<td>Nurse</td>
</tr>
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<td>Nurse</td>
</tr>
<tr>
<td>Nicole Ramsamy</td>
<td>Nurse Practitioner/Midwife, Weipa Integrated Health Service, Torres and Cape HHS</td>
<td>Nurse</td>
</tr>
<tr>
<td>Trina Maturanec</td>
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<td>Nurse</td>
</tr>
<tr>
<td>Warren Cleall</td>
<td>Nurse Unit Manager, Coronary Care Unit, Townsville Hospital, Townsville HHS</td>
<td>Nurse</td>
</tr>
</tbody>
</table>
Appendix 2  General referral information

The introduction of CPC does not remove the need for each referral to contain general information about the referring practitioner and general demographic and clinical information about the patient.

Consistent with the Queensland Health Outpatient Services Implementation Standard and literature on necessary content for good quality referrals, Queensland HHSs typically request the information below in every referral.

During initial consultations on CPC, suggestions have been made by GPs and HHS staff on clarifying information that would be useful to facilitate shared care and improve the prioritising and scheduling of outpatient appointments and further interventions. These items are marked with an asterisk (*).

<table>
<thead>
<tr>
<th>Patient’s demographic details</th>
<th>Referring practitioner details</th>
<th>Relevant clinical information about the condition</th>
<th>Reason for referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full name (including aliases)</td>
<td>• Full name</td>
<td>• Presenting symptoms (evolution and duration)</td>
<td>• To establish a diagnosis</td>
</tr>
<tr>
<td>• Date of birth (and country of birth)</td>
<td>• Full practitioners address</td>
<td>• Physical findings</td>
<td>• For treatment or intervention</td>
</tr>
<tr>
<td>• Residential and postal address, (including if resides at an aged care facility)</td>
<td>• Contact details – telephone, fax, email</td>
<td>• Details of previous treatment and outcome (including systemic and topical medications prescribed and outcomes of previous treatment)</td>
<td>• For advice and management</td>
</tr>
<tr>
<td>• Telephone contact number/s – home, mobile and alternative</td>
<td></td>
<td>• All conservative options that have been pursued unsuccessfully prior to referral</td>
<td>• For specialist to take over management</td>
</tr>
<tr>
<td>• Email address</td>
<td></td>
<td>• Body mass index (BMI)*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Details of any associated physical factors which may affect the condition or its treatment (e.g. diabetes, body mass index)</td>
<td>• For a specified test/investigation the GP can’t order, or the patient can’t afford or access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Current medications and dosages</td>
<td>• Reassurance for the patient/family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Drug allergies</td>
<td>• For other reason (e.g. rapidly accelerating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alcohol, tobacco and other drugs use ii*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A comprehensive capture of information in relation to CPC where applicable</td>
<td></td>
</tr>
</tbody>
</table>
- For reassurance for GP/second opinion disease progression
- Clinical judgement indicates a referral for specialist review is necessary

**Clinical modifiers**

- Impact on employment
- Impact on education
- Impact on home
- Impact on activities of daily living functioning – low/medium/high
- Impact on ability to care for others*
- Impact on personal frailty or safety*
- Identifies as Aboriginal and/or Torres Strait Islander

**Other relevant information**

- Willingness to have surgery (where surgery is a likely intervention)
- Choice to be treated as a public or private patient
- Compensable status (e.g. DVA, Work Cover, Motor Vehicle Insurance, etc.)
- Any special care requirements where relevant (e.g. tracheostomy in place, oxygen required)
Appendix 3  Urgency categorisation for outpatients

There is currently no national standardised categorisation for the first outpatient appointment. In Queensland, categorisation has been aligned to national elective surgery categorisation with public outpatient referrals services triaged into one of three urgency categories as defined in the Outpatient Implementation Standard: Timeframes for appointment are from the date that the referral has been validated and accepted by the relevant outpatient department.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appointment <strong>within</strong> 30 days</td>
<td>• Appointment <strong>within</strong> 90 days</td>
<td>• Appointment <strong>within</strong> 365 days</td>
</tr>
</tbody>
</table>

The urgency category should be appropriate to the patient and their clinical situation as indicated by CPC where appropriate, or as per endorsed local triaging guidelines. It must not be influenced by the perceived or actual availability of resources.

The clinical situation is taken to encompass the patient’s medical condition and the patient’s life circumstances, including issues related to activity limitations, restrictions in participation in employment and other life situations and access to carer and other supports.
Appendix 4 Named referrals

Named referrals are not required when referring to a public outpatient service. However, where a patient chooses to be treated as a private patient a named referral is required in order to meet the requirements of the National Health Reform Agreement and Medicare Benefits Schedule (MBS).

Most publicly employed specialists have access to Granted Private Practice (also known as a right of private practice) as part of their employment arrangements. These arrangements provide patients with a choice of treating doctor and in turn, enable staff specialists to earn additional income through private practice. Granted Private Practice is a fundamental component of medical workforce recruitment and retention strategies, further benefiting patients in terms of the quality and range of public hospital services available.

If a referred patient chooses to be seen in a private clinic operating from a public health service, the patient (or the HHS, with the patient’s consent) needs to obtain a named referral from the referring practitioner. It should be noted that in almost all cases where a patient chooses to be treated as a private outpatient they are bulk billed and therefore have no out of pocket expenses.

The requirements of the National Health Reform Agreement are reflected in the Queensland Health Outpatient Services Implementation Standard as follows:

<table>
<thead>
<tr>
<th>National Health Reform Agreement</th>
<th>Queensland Health Outpatient Services Implementation Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>G17(c): referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.</td>
<td>5.5.2: All referrals to a private (including bulk-billed) outpatient service will be to a named specialist / consultant with a right of private practice.</td>
</tr>
<tr>
<td>G19: An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:</td>
<td>5.5.3: All hospitals will ensure that patients are provided with the option to attend a public or private (including bulk-billed) outpatient service.</td>
</tr>
<tr>
<td>a. there is a third-party payment arrangement with the hospital or the State or Territory to pay for such services; or</td>
<td>• Referral pathways will not be designed nor controlled so as to deny access to free public hospital outpatient services.</td>
</tr>
<tr>
<td>b. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.</td>
<td>• Referrals to a named specialist will not be a prerequisite for access to outpatient services.</td>
</tr>
</tbody>
</table>

Within the public system, named referrals sometimes occur between public specialists, for example referring to a sub-specialist. This can assist in ensuring referrals within or between specialties are appropriately directed; however, is not a requirement to access the publicly funded services. A named referral would only be required if the specialist or sub-specialist is exercising a right of private practice and the patient chooses to be treated as a private patient.
Appendix 5  Scope of publicly funded services

As is the case in other state public health systems in Australia and internationally, not all types of health services are publicly funded in the Queensland health system.

The Queensland Health Scope of Publicly Funded Services Policy outlines the broad intent and principles to inform the types of services that are appropriate for public funding, and the Guideline specifies the out-of-scope services, the operational management of the policy and managing exceptions to the policy.

The intent of the Scope of Publicly Funded Services Policy is to ensure public resources are allocated where the health benefit or health need is greatest.

Typically, but not always, out-of-scope services are services that if undertaken in a private facility would not attract a Medicare Benefit (e.g. cosmetic surgery). Other services currently listed as out-of-scope, regardless of whether they attract a Medicare Benefit, include:

• varicose veins (except where there is significant dysfunction or disability, or venous ulcers)
• vasectomies and reversal of vasectomies
• laser refraction.

Exceptions can always be made where a procedure is clinically indicated, and this can be approved at the local HHS level.
References


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Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for cardiology. It is a consultation document only. It is not the final format or layout of the CPC and should be read in conjunction with the consultation overview.

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

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In scope for cardiology outpatient services
The following conditions are proposed to be considered under the cardiology CPC:

- Angina / myocardial ischaemia / chest pain
- Atrial fibrillation / flutter
- Heart failure
- Hypertension
- Lipid disorders
- Murmur
- Palpitations
- Supraventricular tachycardia
- Syncope / pre-syncope

In scope paediatric conditions
The following paediatric conditions may be considered under the cardiology CPC:

- Chest pain
- Murmur

Out of scope for cardiology outpatient services
Not all services are funded 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 cardiology service:

- There are no out of scope services for cardiology
Referral to emergency

It is proposed that the following conditions should be sent directly to emergency:

- Suspected pulmonary embolism
- Suspected aortic dissection
- Suspected acute coronary syndrome
- Suspected ischaemic chest pain within 24 hours with any of the following red flags
  - Chest pain that is:
    - severe or ongoing
    - lasting ten minutes or more
    - new at rest or with minimal activity
    - associated with severe dyspnoea
    - associated with syncope / pre-syncope
    - associated with any of the following signs:
      - respiratory rate > 30 breaths per minute
      - tachycardia >120
      - systolic BP <90mmHg
      - heart failure / suspected pulmonary oedema
      - ST elevation or depression
      - complete heart block
      - new left bundle branch block
- Atrial fibrillation / flutter with any of the following red flags
  - haemodynamic instability
  - shortness of breath
  - chest pain
  - syncope/pre syncope/dizziness
  - known Wolff-Parkinson-White
  - neurological deficit indicative of TIA/stroke
- Broad complex tachycardia
- Suspected or confirmed endocarditis, myocarditis or pericarditis

- Acute or chronic heart failure with any of the following red flags
  - ongoing chest pain.
  - increasing shortness of breath.
  - oxygen saturation < 90%.
  - haemodynamic instability:
    - pre-syncope / syncope / severe dizziness
    - altered level of consciousness
    - heart rate > 120 beats per minute
    - systolic BP < 90mmHg
    - recent myocardial infarction (within 2 weeks)
    - pregnant patient
- Hypertensive crisis characterised by systolic BP >180mmHg with any of the following red flags
  - headache
  - confusion
  - blurred vision
  - retinal haemorrhage
  - reduced level of consciousness
  - seizures
  - proteinuria
  - papilloedema
- Palpitations with any of the following red flags
  - ongoing chest pain or shortness of breath
  - loss of consciousness
  - syncope / pre-syncope
  - persisting tachyarrhythmia on ECG
**Unresolved acute supraventricular tachycardia with any of the following red flags**
- syncope
- severe dizziness
- ongoing chest pain
- increasing shortness of breath
- hypotension
- signs of cardiac failure
- ventricular rate >120

**Syncope with any of the following red flags**
- exertional onset
- chest pain
- persistent hypotension (systolic BP <90mmHg)
- severe persistent headache
- focal neurologic deficits
- preceded by palpitations
- associated injury
- known ischaemic heart disease with reduced LV systolic function
- prolonged QT interval (corrected on resting ECG)

**Pacemaker/ICD**
- delivery of 2 or more shocks by ICD in 24 hours
- suspected pacemaker/defibrillator malfunction (with ECG evidence)
- pacemaker/ICD device erosion

**Bradycardia including any of the following:**
- symptomatic bradycardia
- symptomatic first degree block
- second degree or complete heart block
# Referral and outpatient criteria

## Angina / myocardial ischaemia / chest pain (adult)

### Referral to emergency

- Suspected acute coronary syndrome
- Suspected pulmonary embolism or aortic dissection
- Suspected ischaemic chest pain within 24 hours with any of the following **Red flags**

**Red flags**

Chest pain that is:
- severe or ongoing
- lasting ten minutes or more
- new at rest or with minimal activity
- associated with severe dyspnoea
- associated with syncope / pre-syncope
- associated with any of the following signs:
  - respiratory rate > 30 breaths per minute
  - tachycardia >120
  - systolic BP < 90mmHg
  - heart failure / suspected pulmonary oedema
  - ST elevation or depression
  - complete heart block
  - new left bundle branch block

### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat</th>
<th>30 days</th>
<th>90 days</th>
<th>365 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat 1</td>
<td>New recurrent cardiac chest pain without <strong>Red flags</strong> (see emergency section)</td>
<td>Chronic suspected cardiac chest pain without Red flags (see emergency section) for investigation</td>
<td>No category 3 criteria</td>
</tr>
<tr>
<td>Cat 2</td>
<td>Prolonged, severe, worsening pattern of angina without <strong>Red flags</strong> (see emergency section) in patients with established coronary heart disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Essential referral information

- General referral information

### Additional referral information

- Investigations relevant to significant comorbidities
### Clinical Prioritisation Criteria

- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy
- Past medical history and comorbidities
- Patient’s functional status
- Family history of premature cardiac disease or sudden cardiac death
- History of smoking and drug use (including alcohol)
- FBC, ELFTs, fasting lipids, HbA1c (if diabetic) results
- ECG

**Cardiovascular risk assessment score**

- Other investigations (if available) including CXR, cardiac imaging: stress ECG, stress echo or myocardial perfusion scan

### Other useful information for referring practitioners (not exhaustive)

- For patients with probable stable angina, commence aspirin, nitro-lingual spray and B-Blockers if no contraindication (ultimately may require ACE I and statin as well). Encourage risk factor modification and smoking cessation.

- Chest pain that is atypical for myocardial ischaemia (ie not crushing or pressing; no radiation to neck, shoulder or arm,) occurring in patients with no or few coronary risk factors (TIMI scores of 0 or 1) is highly unlikely to be cardiac in origin and may be referred to a general physician rather than a cardiologist depending on local services.

- 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 a 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.

### Atrial fibrillation / flutter (adult)

**Referral to emergency**

- Atrial fibrillation / flutter with any of the following Red flags

  **Red flags**
  - haemodynamic instability
  - shortness of breath
  - chest pain
  - syncope/pre syncope/dizziness
  - known Wolff-Parkinson-White
  - neurological deficit indicative of TIA/stroke
### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1 (30 days)</th>
<th>Cat 2 (90 days)</th>
<th>Cat 3 (365 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- New atrial fibrillation/flutter without <strong>Red flags</strong> (see emergency section)</td>
<td>- Chronic atrial fibrillation requiring management review (e.g. rate control, anticoagulation)</td>
<td>- No category 3 criteria</td>
</tr>
<tr>
<td>- Recurrent paroxysmal atrial fibrillation / flutter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Essential referral information

(referral will be rejected without this)

- General referral information
- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy
- Past medical history and comorbidities
- Family history of sudden cardiac death
- History of smoking, alcohol intake and drug use (including recreational drug use)
- FBC, ELFTs, TSH, coagulation studies, magnesium, fasting lipids results
- **All available ECGs (including ECG showing arrhythmia)**
- CHADS VASC score

### Additional referral information

(information that could be useful but is not essential to processing the referral)

- Any investigations relevant to any co-morbidities
- Other investigations (if available) eg echocardiogram report, CXR report, holter monitor report

### Other useful information for referring practitioners (not exhaustive)

- Not all patients have to be seen by a cardiologist if the general practitioner is comfortable caring for the patient.
- In patients with new onset atrial arrhythmias (<48 hours), consider a fast track approach via telephone contact with the nearest cardiology service for consideration of earlier cardioversion to minimize the burden of atrial arrhythmia.

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 a 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.
### Chest pain (paediatric)

#### Referral to emergency
- Current chest pain with haemodynamic compromise

#### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>Exertional chest pain in a child known to have a cardiac abnormality or Kawasaki Disease</td>
<td>Exertional chest pain in a child without a previous history of cardiac abnormality</td>
</tr>
<tr>
<td>90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No category 3 criteria</td>
</tr>
</tbody>
</table>

#### Essential referral information
(referral will be rejected without this)
- General referral information
- Medical history including gestational history
- Details of any known cardiac conditions
- Details of relevant signs and symptoms
- Details of any treatments offered and efficacy
- ECG

#### Additional referral information
(information that could be useful but is not essential to processing the referral)
- Investigations (if available) including CXR, cardiac imaging or echocardiogram

#### Other useful information for referring practitioners (not exhaustive)
- Non-exertional chest pain should be referred to General Paediatrics in the first instance.
- If you have a reason to suspect a child in Queensland is experiencing harm, or is at risk of experiencing harm, you need to contact Child Safety Services: [https://www.communities.qld.gov.au/](https://www.communities.qld.gov.au/)
- In the majority of cases it is thought inappropriate for children to wait more than 6 months for an outpatient initial appointment

- 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 a 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.
## Heart failure (adult)

### Referral to emergency

- Acute or chronic heart failure with any of the following **Red flags**
  
  **Red flags**
  - NYHA Class IV heart failure
  - ongoing chest pain.
  - increasing shortness of breath
  - oxygen saturation < 90%
  - signs of acute pulmonary oedema
  - haemodynamic instability:
    - pre-syncope / syncope / severe dizziness
    - altered level of consciousness
    - heart rate > 120 beats per minute
    - systolic BP < 90mmHg
  - recent myocardial infarction (within 2 weeks)
  - pregnant patient
  - signs of myocarditis
  - signs of acute decompensated heart failure

### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>90 days</td>
<td>365 days</td>
</tr>
</tbody>
</table>

- Heart failure **NYHA Class II-III** with worsening symptoms but without **Red flags** (see emergency section)
- Stable **NYHA Class II** heart failure
- Chronic **NYHA Class I** heart failure with worsening symptoms
- Newly diagnosed **NYHA Class I** heart failure
- Suspected heart failure with mild symptoms equivalent to **NYHA Class II**
- No category 3 criteria

### Essential referral information

- General referral information
- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy

### Additional referral information

- Sleep study report if OSA suspected
- Stress test report (if performed)
- Investigations relevant to co-morbidities
- Relevant previous medical history and co-morbidities
- Weight, height & BMI
- Recent fluctuations in weight indicative of cardiac dysfunction (if known)
- Smoking and alcohol history
- New York Heart Association (NYHA) class
- FBC, ELFTs, fasting lipids, HbA1c (if diabetic), TSH, urinalysis results
- ECG
- CXR report

**Other useful information for referring practitioners** (not exhaustive)

- The Heart Foundation’s [Heart Failure Guidelines](#) and the European Society of Cardiology guidelines provide some additional information regarding patient management

- 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 a 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.

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**Hypertension (adult)**

**Referral to emergency**

- Hypertensive crisis characterised by systolic BP >180mmHg with any of the following **Red flags**
  - headache
  - confusion
  - blurred vision
  - retinal haemorrhage
  - reduced level of consciousness
  - seizures
  - proteinuria

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**Respiratory function tests if patient a smoker, has COPD or asthma**

- Echocardiogram report
- BNP results
Clinical Prioritisation Criteria - 12 -

- papilloedema

### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>30 days</th>
<th>Cat 2</th>
<th>90 days</th>
<th>Cat 3</th>
<th>365 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe persistent hypertension (&gt;180/110) without Red flags (see emergency section)</td>
<td>• Hypertension that is difficult to control</td>
<td>• No category 3 criteria</td>
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<td></td>
</tr>
</tbody>
</table>

### Essential referral information

- General referral information
- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy
- BP
- Relevant previous medical history and co-morbidities
- FBC, ELFTs, fasting lipids results
- Urinalysis results
- Urinary protein estimation results
- CXR report
- ECG

### Additional referral information

- Any investigations relevant to co-morbidities
- Stress test report (if available)
- Renal duplex report if renal artery stenosis suspected
- Smoking and alcohol history

### Other useful information for referring practitioners (not exhaustive)

- Consider testing for primary hyperaldosteronism, and phaeochromocytoma
- Refer to HealthPathways for assessment and management information if available.
- The [Heart Foundation’s Hypertension Guidelines](#) provide some additional guidance for patient management

- 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 a 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.

### Lipid disorders (adult)

#### Referral to emergency

- No referral to emergency criteria

#### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>90 days</td>
<td>365 days</td>
</tr>
</tbody>
</table>

- **Cat 1**
  - Total cholesterol > 10 mmol/l and triglyceride < 10 mmol/l in patient having had cardiovascular event in the preceding 3 months
  - Total triglyceride > 50 mmol/l in patient having had episode of pancreatitis in the previous 3 months

- **Cat 2**
  - The following conditions not responsive to maximal tolerated therapy or statin intolerance
    - Hypercholesterolaemia
    - Hypertriglyceridaemia
    - Dyslipidaemia
    - Statin intolerance

- **Cat 3**
  - Hyperlipidaemia not able to be managed in general practice (reason must be provided eg patient refusing advice)
  - Patients with suspected familial hypercholesterolaemia
  - High cardiovascular risk +/- raised calcium score on CT

#### Essential referral information

(referral will be rejected without this)

- General referral information
- Details of all treatments offered and efficacy
- Relevant previous medical history and co-morbidities (especially cardiovascular disease)
- BP
- ELFTs, HbA1c, TSH, CK results
- Fasting lipid results (cholesterol/ triglyceride/ HDL-cholesterol/ LDL-cholesterol)

#### Additional referral information

(information that could be useful but is not essential to processing the referral)

- Smoking and alcohol history
- Family history of hyperlipidaemia
- Previous lipid results (serial if available)
- Any imaging confirming presence of cardiovascular disease
- Coronary artery calcium score

#### Other useful information for referring practitioners

(not exhaustive)

Clinical Prioritisation Criteria - 13 -
• Consider commencing statins depending on other cardiac risk factors
• Depending on cardiac risk factors consider commencing statins
• The Heart Foundation's Lipid Management Guidelines provide some additional guidance for patient management
• The QRISK®2 calculator is helpful in assessing cardiovascular disease risk

• 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.

### Murmur (adult)

#### Referral to emergency

- New murmur with any of the following **Red flags**
  - heamodynamic instability
  - persistent or progressive shortness of breath (NYHA Class III – IV)
  - chest pain
  - syncpe / pre-syncpe / dizziness
  - neurological deficit indicative of TIA/stroke
  - abnormal ECG (e.g. LV hypertrophy, AF, LBBB, RBBB)
  - fever or constitutional symptoms suggestive of infection (endocarditis, rheumatic fever)
  - signs of heart failure

#### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Murmur with heart failure symptoms <em>(NYHA Class II-III)</em></td>
<td></td>
</tr>
<tr>
<td>• Severe valve stenosis or regurgitation on echocardiograph without <strong>Red flags</strong> (see emergency section)</td>
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<tr>
<td>• Stenosis or regurgitation with left ventricular dysfunction and/or pulmonary</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cat 2</th>
<th>90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Murmur with heart failure symptoms <em>(NYHA Class I-II)</em></td>
<td></td>
</tr>
<tr>
<td>• Moderate valve stenosis or regurgitation with normal ventricular function, and no pulmonary hypertension</td>
<td></td>
</tr>
<tr>
<td>• Previous valve surgery with new heart</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cat 3</th>
<th>365 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Asymptomatic murmur</td>
<td></td>
</tr>
<tr>
<td>• Mild valve stenosis or regurgitation on echocardiograph with normal ventricular function and no pulmonary hypertension</td>
<td></td>
</tr>
</tbody>
</table>
### Essential referral information
(Referral will be rejected without this)
- General referral information
- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy
- Past medical history (including rheumatic fever) and comorbidities
- Family history of sudden cardiac death or premature coronary artery disease
- History of smoking and drug use (including alcohol)
- FBC, ELFTs, TSH, fasting lipids results
- ECG
- Exercise tolerance

### Additional referral information
(Information that could be useful but is not essential to processing the referral)
- Echocardiogram report
- CXR report
- Include if appropriate gestational and development history

### Other useful information for referring practitioners (not exhaustive)
- If structural heart disease is suspected an echocardiogram should be arranged.

- 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 a 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.
**Murmur (paediatric)**

### Referral to emergency
- Infant <3 months with newly noted murmur and any of the following:
  - poor feeding
  - slow weight gain
  - weak or absent femoral pulses
  - post ductal (foot) oxygen saturation < 95%
  - respiratory signs (wheeze, recession or tachypnoea)

### Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>90 days</td>
<td>365 days</td>
</tr>
</tbody>
</table>

- Asymptomatic murmur in a baby from birth to 3 months
- Asymptomatic murmur at any age in association with acute rheumatic fever
- Murmur with cyanosis, heart failure, syncope or seizures
- Asymptomatic murmur in a child aged 4 months to 2 years
- Murmur at any age with a past history of rheumatic fever
- Asymptomatic murmur in a child over 2 years old

### Essential referral information
****(referral will be rejected without this)****
- General referral information
- Physical findings including colour assessment or oxygen saturation
- Report presence or absence of the following **Red flags**
  - History of exercise intolerance
  - Cyanotic episodes or blue spells
  - Weak or absent femoral pulses
  - Clubbing

### Additional referral information
****(information that could be useful but is not essential to processing the referral)****
- Highly desirable information – may change triage category
  - Known other congenital abnormalities
  - Family history of congenital cardiac disease
  - Aboriginal or Torres Strait Islander or Maori status (rheumatic fever risk)

- Desirable information- will assist at consultation
  - Other past medical history
  - Immunisation history
  - Developmental history
  - Medication history
  - Significant psychosocial risk factors (especially parents mental health,
family violence, housing and financial stress, department of child safety involvement)
- Height/weight/head circumference and growth charts with prior measurements if available.
- Other physical examination findings inclusive of CNS, birth marks or dysmorphology
- Any relevant laboratory results or medical imaging reports, urinalysis result

Other useful information for referring practitioners (not exhaustive)
- If structural heart disease is suspected an echocardiogram should be arranged.
- If you have a reason to suspect a child in Queensland is experiencing harm, or is at risk of experiencing harm, you need to contact Child Safety Services: [https://www.communities.qld.gov.au/](https://www.communities.qld.gov.au/)
- In the majority of cases it is thought inappropriate for children to wait more than 6 months for an outpatient initial appointment

- 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 a 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.

Palpitations (adult)

**Referral to emergency**

- Palpitations with any of the following **Red flags**

  **Red flags**
  - chest pain
  - shortness of breath
  - loss of consciousness
  - syncope / pre-syncope
  - persisting tachyarrhythmia on ECG

Minimum referral criteria
<table>
<thead>
<tr>
<th>Cat 1 (30 days)</th>
<th>Cat 2 (90 days)</th>
<th>Cat 3 (365 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Palpitations in the presence of underlying cardiac disease</td>
<td>• No category 2 criteria</td>
<td>• Frequent or persistent palpitations with no haemodynamic features</td>
</tr>
<tr>
<td>• Palpitations with abnormal ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Frequent and persistent palpitations with haemodynamic features</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Essential referral information**  
(referral will be rejected without this)
- General referral information
- Details of relevant signs and symptoms including duration and frequency of episodes
- History of underlying cardiac disease
- Family history of sudden cardiac death
- ELFTs, TSH and Magnesium results
- All available ECGs (during episodes if possible)

**Additional referral information**  
(information that could be useful but is not essential to processing the referral)
- Holter monitor report and all ECG tracings (useful if symptoms are present on almost a daily basis)
- Echocardiogram report
- Stress test report
- Caffeine intake, alcohol intake and drug use (including recreational drug use)

**Other useful information for referring practitioners**  
(not exhaustive)
- ECG at the time of palpitation (even if normal) may have important diagnostic clue.

- 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 a 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.
# Supraventricular tachycardia (adult)

## Referral to emergency

- Unresolved acute supraventricular tachycardia with any of the following **Red flags**
  
  **Red flags**
  - syncope
  - severe dizziness
  - ongoing chest pain
  - increasing shortness of breath
  - hypotension
  - signs of cardiac failure
  - ventricular rate >120

## Minimum referral criteria

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>Cat 2</th>
<th>Cat 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 days</td>
<td>90 days</td>
<td>365 days</td>
</tr>
</tbody>
</table>

- **Cat 1**
  - Supraventricular tachycardia without **Red flags** (see emergency section) but requiring medical intervention

- **Cat 2**
  - Documented evidence of pre-excitation on ECG with history of palpitations

- **Cat 3**
  - No category 3 criteria

## Essential referral information

**General referral information**

- Medication history
- ELFTs, FBC, TSH results

**Additional referral information**

- All available ECGs (including an ECG showing SVT if possible)
- Details of relevant signs and symptoms
- Details of all treatments offered and efficacy
- Relevant previous medical history and co-morbidities
- Caffeine intake, alcohol intake and drug use (including recreational drug use)
- Echocardiogram report
- Stress test report
- CXR report

## Other useful information for referring practitioners (not exhaustive)

- Echocardiogram report
- Stress test report
- CXR report
If isolated in the absence of syncope/haemodynamic compromise:
  - reassure
  - consider vagolytic manoeuvres

Consider holter monitor if frequent (daily or second daily)
Consider event recorder if infrequent

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.

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**Syncope / pre-syncope (adult)**

**Referral to emergency**

- Syncope with any of the following Red flags

  **Red flags**
  - exertional onset
  - chest pain
  - persistent hypotension (systolic BP <90mmHg)
  - severe persistent headache
  - focal neurological deficits
  - preceded by palpitations
  - associated injury
  - known ischaemic heart disease with reduced LV systolic function
  - prolonged QT interval (corrected on resting ECG)

**Minimum referral criteria**

<table>
<thead>
<tr>
<th>Cat 1</th>
<th>30 days</th>
<th>Cat 2</th>
<th>90 days</th>
<th>Cat 3</th>
<th>365 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>New episode(s) of syncope / near syncope without <strong>Red flags</strong> (see emergency section)</td>
<td>Recurrent syncope previously investigated with undetermined cause</td>
<td>No category 3 criteria</td>
<td></td>
<td></td>
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</tbody>
</table>

**Essential referral information**

- General referral information

**Additional referral information**

- Holter monitor report (only useful if daily symptoms)
- Details of all treatments offered and efficacy
- Relevant medical history (consider timeline, precipitating factors, any warning pre-syncopal symptoms, complete LOC or partial, duration of LOC, nature of recovery, witnessed signs, seizures, pallor, incontinence, cyanosis, irregular or absent pulse during attack, associated injury).
- Lying / standing or sitting / standing BP
- Family history of sudden cardiac death or premature coronary artery disease
- Presence of impaired LV function by any imaging modality (MRI, echo or MPS) if known
- FBC, TSH, ELFTs, magnesium results
- All available ECGs

Other useful information for referring practitioners (not exhaustive)

- The [NICE (UK) Guidelines for transient loss of consciousness](https://www.nice.org.uk/guidance) may provide guidance on assessment and management.
- Syncope may impact on a patient's medical fitness to drive. [Queensland Government’s Transport and Motoring website](https://transport.qld.gov.au) has advice about managing driving.
- 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 a 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.

- Echocardiogram report
- CXR report
- Syncope that is suspected to be of non-cardiac origin may be referred to a general physician rather than a cardiologist depending on local services.
## Intervention criteria

### Out of scope for cardiology interventions

Not all services are funded 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 cardiology service:

- Please include any interventions that are not routinely delivered in public cardiology services and/or should be considered out of scope.

### Urgency category for intervention

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Minimum criteria</th>
<th>Urgency</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Please add suggested urgency category</td>
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## Version control

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<th>Date</th>
<th>Author</th>
<th>Nature of amendment</th>
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<td>CPC team (Katie Wykes and Mel Marriott)</td>
<td>Initial version</td>
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<td>7/06/2017</td>
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<td>Drafting and iterations</td>
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<td>31/07/2017</td>
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<td>Drafting following review by clinical lead.</td>
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<td>Revisions following CAG Round 1 feedback and inclusion of paediatric conditions</td>
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<td>1/11/17</td>
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<td>Revision of paediatric conditions following discussion with LCCH clinicians</td>
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<td>0.07</td>
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<td>Amendments (minor) following CAG endorsement round</td>
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References


