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REFERRAL GUIDELINES: COLORECTAL SURGERY

Essential Referral Content

Demographic

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements
- Medicare number

Clinical

- Reason for referral
- Duration of symptoms
- **Relevant pathology, imaging and colonoscopy reports**
- Past medical history
- Current medications

Please ensure you patient brings relevant pathology, imaging and colonoscopy reports if available to their appointment

Exclusion Criteria

The Alfred Outpatient Referral Form is available to print and fax to the Outpatient Department on 9076 6938

The following conditions are not routinely seen by the Alfred Colorectal unit:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen at The Alfred

REFERRAL PROCESS: COLORECTAL SURGERY

STEP 1

You will be notified when your referral is received by outpatients.

Essential referral content will be checked and you may be contacted for further information if required.

STEP 2

The referral is triaged by the specialist unit according to clinical urgency.

This determines how long the patient will have to wait for an appointment.

STEP 3

Patients with **urgent** conditions are scheduled to be seen within 30 days. Patients with **routine** conditions are given the next available appointment according to clinical need.

Both the referrer and patient are notified.

Please note: The times to assessment may vary depending on size and staffing of the hospital department.

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Colorectal Fellow or Registrar on call on 9076 2000.

The Alfred gratefully acknowledges the assistance of the Canterbury and District Health Board in New Zealand in developing these guidelines.
They are intended as a guide only and have been developed in conjunction with the Heads of Unit of The Alfred.

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REFERRAL PRIORITY: COLORECTAL SURGERY

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

IMMEDIATE **Direct to the Emergency & Trauma Centre**	URGENT **Appointment timeframe within 30 days**	ROUTINE **Appointment timeframe greater than 30 days**
• Diverticulitis with systemic sepsis • Large bowel obstruction • Severe PR bleeding • Perianal abscess	• Confirmed or suspected colorectal cancer	
Phone the Colorectal Fellow or Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.	Urgent cases must be discussed with the Colorectal Fellow or Registrar on call to obtain appropriate prioritisation and a referral letter faxed to 9076 6938.	Fax referral to 9076 6938

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Colorectal Fellow or Registrar on call on 9076 2000.

Referral Guideline Contents

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DISEASES OF THE COLON

Evaluation	Management	Referral Guidelines
History including: • Family history • Altered bowel habit • Tenesmus • Mass • Incomplete rectal emptying **Also refer to the** Gastroenterology Referral Guidelines	Acute mild diverticulitis: antibiotics.	Patients with: • diverticulitis with systemic sepsis • large bowel obstruction • severe PR bleeding should be **referred immediately** to the Alfred Emergency and Trauma Centre. Patients with diagnosed recurrent attacks of **diverticulitis** should be referred to the Colorectal Clinic for specialist opinion. Patients with suspected or proven **inflammatory bowel disease** should be referred to the Gastroenterology Inflammatory Bowel Disease Clinic (Wednesday mornings)

CONFIRMED COLORECTAL CANCER

Evaluation	Management	Referral Guidelines
History including: • Weight loss • Medications • Ascites • Tenesmus • History of Malignancy • PR blood, pus, or mucus • Altered bowel habit • Flatus • Incomplete rectal emptying • Family history of inflammatory bowel disease, polyposis or cancer **Investigations** • FBE • LFTs • CEA • CT Scan of chest, abdomen and pelvis • Biopsy result • Colonoscopy or Barium enema result The Alfred Radiology request form	Consider iron replacement while awaiting investigations	• Patients with **confirmed colorectal cancer** refer **urgently** to the Colorectal Outpatient Clinic : contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice.

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SUSPECTED COLORECTAL CANCER

Evaluation	Management	Referral Guidelines
History including: • Weight loss • Medications • Ascites • Tenesmus • History of Malignancy • PR blood, pus, or mucus • Altered bowel habit • Flatus • Incomplete rectal emptying • Family history of inflammatory bowel disease, polyposis or cancer **Investigations** • FBE • LFTs • Colonoscopy		Patients who have signs or symptoms **suggestive of colorectal cancer** should be referred for **urgent** outpatient appointment for colonoscopy. Patients with **suspicious bleeding or definite change in bowel habit** should be referred to the Colorectal Outpatient clinic for colonoscopy. Patients who **have vague lower abdominal or change in bowel habits** (to constipation) should be referred for **Open Access Endoscopy clinic:** The Alfred Gastrointestinal Endoscopy Service request form Endoscopy Referral Guidelines Gastroenterology Service Contact the Colorectal Fellow or Registrar through The Alfred switchboard on 9076 2000 to discuss urgent referral or for advice. Guidelines for screening colonoscopy – refer to NH&MRC Colorectal cancer guidelines

HAEMORRHOIDS

Evaluation	Management	Referral Guidelines
• History of ano-rectal bleeding • Prolapse and thrombosis • Evaluation: - PR - Proctoscopy - Sigmoidoscopy	• Lifestyle/dietary advice/ modification • Proprietary creams/ suppositories	• Refer for colonoscopy if underlying disease suspected • Points for concern: - An associated change in bowel habit - Blood mixed with stool - Associated pain and discomfort in the absence of thrombosis or other pathology such as a fissure - Palpable mass on rectal examination - Copious bleeding with associated anaemia

ANAL FISTULA

Evaluation	Management	Referral Guidelines
• History of recurrent perianal abscesses, discharge sinus, and pervious drainage operation • Evaluation: - PR - Proctoscopy - Sigmoidoscopy		Refer to CRS clinic for management and exclusion of associated disease

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ANAL FISSURE

Evaluation	Management	Referral Guidelines
• History of pain with and after defecation. • Attacks may be intermittent or prolonged • Evaluation may be difficult due to spasm • Note anal tag	Rectogesic/faecal softeners	Refer to CRS clinic for management and exclusion of associated disease