

Referral Guidelines: Direct Access Gastrointestinal Endoscopic Procedures

Referrals for patients deemed not to meet the clinical indications for referral will be returned to the referrer for clinical review.

Who needs endoscopy?

There is a high demand for gastrointestinal endoscopy services across the health system; therefore it is essential to identify those patients that need procedures most urgently.

In WA, cancers are found in less than 2% of colonoscopies and <1% of upper gastrointestinal endoscopies (WA DoH Data, 2014).

The following are guidelines to help referrers identify patients who have a higher likelihood of significant organic pathology and, to help reduce the number of unnecessary endoscopy referrals.

Essential Referral Requirements

- Referrals for direct access endoscopy must be made using the Request for Direct Access Gastrointestinal Endoscopy (Adult) [form](#).
- All [mandatory fields](#) must be complete for the referral to be accepted. Incomplete referrals will be returned to the referring doctor.
- All non-urgent referrals must be sent to the Central Referral Service – either via fax (1300 365 056) or secure messaging (HealthLink address/ID: crefserv).
- Referrals for patients who require immediate review (within the next seven days) should be referred directly to the appropriate, local hospital in consultation with the Gastroenterology Service.
- Patients who have co-morbidities may be reviewed in the appropriate outpatient clinic prior to consideration of endoscopy.

Referral Decision and Acceptance Considerations

- Referrals will only be accepted if they are submitted on the Request for Direct Access Gastrointestinal Endoscopy (Adult) [form](#), and all [mandatory fields](#) are complete.
- All referrals are triaged and appointments are provided based on clinical priority. The guidelines used for clinical urgency categorisation are summarised [here](#).
- Where there is clear-cut concern about the presence of serious GI pathology on the basis of [symptoms described below](#), *especially in high risk patient groups*, referral for endoscopy is appropriate and patients will be waitlisted for their procedure. The risk factors should be clearly stated on the referral to assist the triage process.
- Where there is reasonable clinical uncertainty, and patients don't meet the criteria for referral or other investigative action, *especially in lower risk patient groups and in those whose symptoms are of short duration*, it is recommended to arrange a GP review for a future date (suggested 6-12 weeks but this is a clinical decision that remains the responsibility of the GP). The NICE guidelines (2015) recommend that the review in these circumstances may be*:
 - Planned within a time frame agreed with the person **or**
 - Patient initiated if new symptoms develop, the person continues to be concerned, or their symptoms recur, persist or worsen.

**as per the safety netting recommendations in NICE guidelines (2015)*

<https://www.nice.org.uk/guidance/NG12/chapter/Recommendations-on-patient-support-safety-netting-and-the-diagnostic-process#safety-netting>

- Referrals for patients deemed not to meet the clinical indication for referral will be returned to the referrer with a brief explanation of the return reason. These referrals will be returned via the CRS, on behalf of the hospital making the triage decision. Hospitals will be responsible for managing communication with patients regarding the status of their referrals.

Referral Process

Step 1	Step 2	Step 3	Step 4	Step 5
<p>Referral is made using the Request for Direct Access Gastrointestinal Endoscopy (Adult) form.</p> <p>Referral is sent to the Central Referral Service (CRS).</p>	<p>Mandatory referral content will be checked.</p> <p>The CRS will contact you if further information is required.</p> <p>You will be notified by the CRS when your referral is received.</p>	<p>The CRS sends the complete referral to the most appropriate hospital based on clinical need and postcode.</p> <p>You will be notified when CRS receives the referral.</p>	<p>The allocated hospital assess if the referral meets access criteria.</p> <p>Meets acceptance criteria - the referral is triaged and waitlisted according to clinical urgency. You will be notified regarding which hospital has accepted the referral.</p> <p>Does not meet acceptance criteria – the referral will be returned with advice why.</p>	<p>The hospital will provide the patient with a date when their procedure date is approaching.</p>

Some general hospitals offer endoscopy services under the Ambulatory Surgery Initiative (ASI). ASI services require a referral to a named specialist, and patients must meet specified criteria. Please note that your patient may be seen by another specialist in the endoscopy facility, in order to expedite their treatment.

Please note: The times to assessment may vary depending on the size and staffing of the hospital department. If you are concerned about the delay of the appointment, or if there is any deterioration in the patient's condition, please contact the Gastroenterology service at the appropriate hospital.

In referring a patient for direct access endoscopy the referrer should:

- Inform the patient about the procedure – patient information can be accessed [here](#).
- Ensure they are willing to undergo the procedure.
- Consider the ability of the patient to tolerate bowel preparation (if relevant) and the procedure.
- Consider whether the patient will benefit if they are frail, have multiple co-morbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment).
- Ensure, if the patient has had a colonoscopy or gastroscopy in the preceding five years, that there is clear indication to repeat the procedure.

General Indications for Referral

Endoscopy is generally INDICATED:

- If a change in management is probable based on the results of the endoscopy
- After an empiric trial of therapy for a suspected benign digestive disorder has been unsuccessful
- As the initial method of evaluation as an alternative to radiographic studies
- When a primary therapeutic procedure is contemplated

Endoscopy is generally NOT indicated:

- When the results will not contribute to a management choice
- For periodic follow-up of healed benign disease unless surveillance of a pre-malignant condition is warranted

Endoscopy is generally CONTRAINDICATED:

- When the risks to the patient's health or life are judged to outweigh the most favourable benefits of the procedure
- When adequate patient cooperation or consent cannot be obtained
- When a perforated viscus is known or suspected

Clinical Indications for Referral: Colonoscopy

Indications for Referral

- Rectal bleeding for >4 weeks
- Positive FOBT result (including National Bowel Cancer Screening Program participants)
- Bloody diarrhoea with negative stool MC&S
- Change in bowel habit >6 weeks with alarm symptoms at any age (persistent rectal bleeding, unexplained progressive weight loss, severe pain, unexplained iron deficiency anaemia, palpable mass, bloody diarrhoea with negative stool MC&S)
- Change in bowel habit >6 weeks without alarm symptoms in patient aged >60yr
- Unexplained iron deficiency anaemia in men or non-menstruating women
- After first episode of proven diverticulitis to exclude neoplasm
- Abnormal imaging
- Active inflammatory bowel disease where endoscopy is indicated to progress management
- Surveillance for past history of bowel cancer, polyps, inflammatory bowel disease
- Surveillance for significant family history of bowel cancer

Alarm symptoms

- Persistent rectal bleeding (>4 wks)
- Unexplained progressive weight loss
- Severe pain
- Unexplained iron deficiency anaemia
- Palpable mass
- Bloody diarrhoea with negative stool MC&S

General Risk Factors for Serious Pathology

- New symptoms that have persisted for >6 weeks
- Patients >60yr
- Unexplained iron deficiency anaemia (especially if >60yr)

Clinical Indications for Referral: Gastroscopy

Indications for Referral

- Unexplained upper GI bleeding (haematemesis, melaena)
- Unexplained iron deficiency anaemia in men and non-menstruating women
- Unexplained recent dyspepsia in patients >55yr
- Unexplained recent dyspepsia in patients <55yr with alarm symptoms
- Dysphagia, odynophagia
- Unexplained upper abdominal pain and weight loss (>10%)
- Persistent vomiting and weight loss
- Reflux refractory to medical therapy
- Upper abdominal mass
- For duodenal biopsy following positive serology in suspected coeliac disease
- Surveillance of Barrett's oesophagus and gastric intestinal metaplasia

Alarm symptoms

- Unexplained iron deficiency anaemia
- Overt bleeding (haematemesis, melaena)
- Dysphagia
- Unexplained progressive weight loss with upper GI symptoms
- Severe pain
- Palpable mass

General Risk Factors for Serious Pathology

- New symptoms that have persisted for >6 weeks
- Unexplained progressive weight loss and anorexia
- Iron deficiency anaemia (especially if >60 yr)
- Patients >60 yr

Recommended Investigations Prior to Referral

The following results/supporting information must be included to support relevant referral indications:

- Abdominal imaging – if performed
- Ferritin and Haemoglobin levels (for unexplained iron deficiency)
- U&E for patients with kidney disease
- LFT/INR/Platelets for patients with liver disease
- A digital rectal examination is essential for any patient with lower bowel symptoms to help exclude a rectal/anal malignancy
- Stool MC&S in patients with chronic diarrhoea

Surveillance Guidelines: Colonoscopy

All patients referred for surveillance colonoscopies after removal of polyps, for family history or following colorectal cancer are triaged according to the guidelines below.

Referrals for patients that require a surveillance colonoscopy in greater than 12 months' time, will be returned to the referrer with advice to re-refer closer to the date the colonoscopy is due.

These guidelines are based on [Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy \(December 2011\)](#).

Family History

Family History	Advice
Average Risk <ul style="list-style-type: none">• No family history• 1 relative affected >55	FOBT 1-2 yearly from age 50
Moderate Risk <ul style="list-style-type: none">• 1st degree relative affected with colorectal cancer (CRC) age <55• Two 1st or 2nd degree relatives on same side of family with CRC• Serrated/Hyperplastic Polyposis Syndrome	Colonoscopy every 5 years from age 50 (or 10 years younger than youngest affected relative) Colonoscopy every 2 years after polyps have been removed
High Risk <i>should be managed by specialist referral centre in collaboration with a genetic diseases service.</i> <ul style="list-style-type: none">• Lynch syndrome (Hereditary Non Polyposis Colorectal Cancer - HNPCC)• Familial Adenomatous Polyposis (FAP)	HNPCC: Colonoscopy 1-2 yearly from age 25 (or 5 years younger than youngest affected relative) FAP: sigmoidoscopy or colonoscopy from 12-15 years of age

After Polypectomy

Finding at Colonoscopy	Interval
1 or 2 tubular adenomas <10mms	5 years
Large adenomas ≥ 10mms	
Advanced adenoma – high grade dysplasia/villous component	3 years
3 or more adenomas	
5 or more adenomas	1 year
Malignant polyps	Clinical discretion (recommend within 3-6 months, then 1 year, then 3 years, then 3-5 yearly)
Piecemeal resection of large sessile polyps (>2cms)	

After Curative Surgery for Colorectal Cancer

Complete examination of the colon before or within 6 months of surgery

Subsequent colonoscopy at 1 year, then as per adenoma surveillance (see box above) – if no polyps detected then 5 yearly surveillance interval

Surveillance Guidelines: Gastroscopy

Referrals for patients with the following indications should be accepted and waitlisted for a surveillance gastroscopy:

Barrett's Oesophagus

Finding at Gastroscopy	Interval
No dysplasia	
Short (<3 cm) segment	3-5 years
Long (>3 cm) segment	2-3 years
'Indefinite for dysplasia' or 'Confirmed dysplasia'	This should be referred and managed at a tertiary centre.

Gastric intestinal metaplasia

If this is a finding at gastroscopy the patient should be referred to a tertiary centre for follow-up in a Gastroenterology outpatient clinic and further surveillance booked as clinically indicated.

Referring to Named Specialists under the Ambulatory Surgery Initiative

The Ambulatory Surgery Initiative (ASI) aims to reduce waiting times for minor procedures. Procedures performed under the ASI are bulk billed so patients incur no out-of-pocket expenses. ASI is available to **low-risk patients with a named referral** to a participating specialist.

If your patient consents to having their procedure under ASI the following section of the gastrointestinal endoscopy referral form needs to be completed:

ASI Eligibility

The Ambulatory Surgery Initiative (ASI) aims to reduce waiting times for minor procedures. Procedures performed under the ASI are bulk billed so patients incur no out-of-pocket expenses. ASI is available to low-risk patients with a named referral to a participating specialist.

If your patient consents to having their procedure under ASI at one of the sites listed, please complete the section below. If this section is not completed, or the patient is deemed ineligible, the referral will be directed to the appropriate public hospital based on catchment area and service capability.

Tick all that apply:

<input type="checkbox"/> <75 years old	<input type="checkbox"/> <120 kg
<input type="checkbox"/> Medicare eligible	<input type="checkbox"/> Free of significant co-morbidities
<input type="checkbox"/> Suitable for a day procedure	

Please select **one or more** of the following Consultants. Note that your patient may be seen by another specialist at the same hospital in order to expedite their treatment.

Mandatory referral information

The following information **must** be provided in the referral form to enable triaging clinicians to determine suitability for direct access, and assign the clinically appropriate urgency category that will support patients being seen in the timeliest manner according to care needs.

If this information is not provided, the referral will be returned to the referrer for completion.

- Referral for: Public Colonoscopy and/or Public Gastroscopy
- Patient Details:
 - Name
 - Date of Birth
 - Gender
 - Contact number
 - Address
 - Medicare number including reference number and expiry date
 - Interpreter required
- Indication for referral:
 - Symptom duration
 - At least one indication must be ticked under the following sections, or an adequate description provided:
 - Lower GI indications
 - Upper GI indications
- Medical history, risk factors and **current** medication list
 - Weight – if exact weight is not known an estimate must be provided
 - Indicate if the patient has cardiac stents/pacemaker/implanted defibrillator (if history of heart disease)
 - List of anti-coagulation medications, and the indication for prescription
 - Family member details (relationship & age of diagnosis) if requesting surveillance for family history of colorectal cancer
- Relevant investigations- the following results/supporting information must be included to support relevant referral information:
 - Abdominal imaging reports – if imaging has been performed
 - Ferritin and Haemoglobin levels (for unexplained iron deficiency)
 - U&E for patients with kidney disease
 - LFT/INR/Platelets for patients with liver disease

Urgency Categorisation Guidelines

The following provides a general indication regarding how triaging clinicians at hospitals assign urgency categorisation to direct access endoscopy referrals.

While it is anticipated that usual urgency categories and surveillance guidelines will be suitable in most circumstances, it is acknowledged that there will be exceptional cases where the urgency category/surveillance interval will vary and a different approach will be clinically appropriate.

Recommended Urgency Categorisation	Symptoms/Description
1	<p>Colonoscopy</p> <ul style="list-style-type: none"> • Rectal bleeding for >4wks • Positive FOBT result • Change in bowel habit >6wks with alarm symptoms (persistent rectal bleeding, unexplained progressive weight loss, severe pain, unexplained iron deficiency anaemia, palpable mass, bloody diarrhoea with negative stool MC&S) at any age • Unexplained iron deficiency anaemia in men or non-menstruating women • Active inflammatory bowel disease where endoscopy is indicated to progress management • Bloody diarrhoea with negative stool MC&S <p>Gastroscopy</p> <ul style="list-style-type: none"> • Unexplained upper GI bleeding (haematemesis, melaena) • Iron deficiency anaemia in men or non-menstruating women • Unexplained recent dyspepsia in patients <55yr with alarm symptoms • Dysphagia, odynophagia • Unexplained upper abdominal pain and weight loss (>10%) • Persistent vomiting and weight loss • Upper abdominal mass
2	<p>Colonoscopy</p> <ul style="list-style-type: none"> • Change in bowel habits >6wks without alarm symptoms in patients >60yr • Abnormal imaging • Diarrhoea >6wks where endoscopy is indicated to progress management <p>Gastroscopy</p> <ul style="list-style-type: none"> • Unexplained recent dyspepsia in patients >55yr • Reflux refractory to medical therapy • For duodenal biopsy following positive serology in suspected coeliac disease
Return to GP	<p>The referral does not meet the WA Health acceptance criteria as described in the referral guidelines.</p> <p>Referrals will be returned to the referrer with advice to “treat, watch and wait”, review in GP practice within 6-12 weeks, and re-refer if the patient’s symptoms persist and are of concern.</p> <p>GPs can contact the Gastroenterology Department at their local hospital if they wish to discuss specific concerns regarding their patient.</p>
Surveillance	<p>Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines) within 12 months of the hospital receiving the referral – the referral will be accepted and waitlisted to have their procedure as close to the due date as possible.</p> <p>Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines) in greater than 12 months from when the hospital receives the referral – the referral will be returned to the referrer, requesting a re-referral closer to the time the procedure is due.</p> <p>Colonoscopy</p> <ul style="list-style-type: none"> • Surveillance for past history of bowel cancer, polyps, inflammatory bowel disease • Surveillance for significant family history of bowel cancer <p>Gastroscopy</p> <ul style="list-style-type: none"> • Surveillance of Barrett oesophagus, gastric intestinal metaplasia

Links to relevant/supporting information

- [Request for Direct Access Gastrointestinal Endoscopy \(Adult\) Form](#)
- [HealthPathways WA – Endoscopy Requests](#)
- Patient Information – [Colonoscopy](#), [Gastroscopy](#)
- [Referral Guidelines: Summary](#)
- [Frequently Asked Questions](#)