Tool 9 Resource: Referral Guidelines from Shasta Ambulatory Care

Excerpt of original document follows.

SHASTA COMMUNITY HEALTH CENTER

Policy: Ambulatory Care Guidelines	**Manual: Medical Staff/Clinical**
Effective Date: October 28, 1998	**Revision Date: Reviewed 02.02.05**
Number of Pages: 61	**Number of Forms: None**
JCAHO STD's: PC 1.10 – 15.30	**Saved As: CMO 2006 Manual**
Approved By: **Medical Directors** **SCHC Board of Directors**	**Date Review/Edited:** **January 3, 2006** **January 24, 2006**

I. Policy:

It is the policy of Shasta Community Health Center to provide ambulatory care guidelines for clinicians.

II. Purpose/Goal:

The purpose of this policy is to provide consistent services to both patients and other medical providers by establishing guidelines for the delivery of primary care services and directives regarding referral consultations.

III. Procedure:

See Following:

GASTROENTEROLOGY

PRIMARY CARE CLINICIAN SHOULD:

1. Diagnose lower abdominal pain by history, physical examination, and appropriate lab work. Sigmoidoscopy should be performed if clinically indicated and if trained. Referral to surgery is appropriate for suspected acute abdomen, such as appendicitis or to gynecology for suspected pelvic disorder. GI consultation may be appropriate if the diagnosis remains uncertain or is refractory to initial therapy.

2. Diagnose acute diarrhea with fecal leukocytes, stool culture if fecal leukocytes positive or suspicion of salmonella, ova and parasites, and sigmoidoscopy if indicated. Treat infectious diarrhea if identified. Refer if the diagnosis remains in question or symptoms do not respond within 72-96 hours of the initiation of therapy.

3. Diagnose conditions associated with changes in stool caliber, tenesmus or an alteration in stable bowel patterns. Evaluation may include a barium enema and flexible sigmoidoscopy or colonoscopy. Refer if polyps or other abnormalities are found or if no diagnosis has been established by examination.

4. Diagnose causes for protracted vomiting and nausea by examination, x-ray, and laboratory. Treat with appropriate outpatient rectal or parenteral medications and IV fluids. GI consultation may be appropriate if the diagnosis is uncertain or the patient is refractory to initial therapy. Refer to surgeon for suspected bowel obstruction.

5. Diagnose and treat heartburn(GERD), upper abdominal pain, and symptoms of reflux or acid peptic disease. Refer for persistent or recurrent symptoms for over eight weeks. Early referral may be appropriate for patients over the age of 50 with new symptoms, patients with guaiac positive stool, or patients with dysphagia or weight loss.

6. Diagnose functional bowel syndrome by history, examination, laboratory or other tests, which may include sigmoidoscopy and barium enema and, if needed, psychiatric evaluation. Treat symptomatically. Refer if abnormalities are found, there is associated bleeding or weight loss, or if symptoms are refractory to therapy.

7. Diagnose jaundice by history, examination, and laboratory including hepatitis serology, ultrasound, and CT scan if indicated. Refer if jaundice is complicated by fever, is progressive, associated with intractable ascites or if there is undiagnosed hepatocellular disease. Refer extrahepatic or intrahepatic bile duct obstruction for GI and surgical consultation.

8. Diagnose and treat patients with pancreatitis, expecting a favorable response to conservative treatment in patients with chronic relapsing pancreatitis. Consult for patients with initial episode of acute pancreatitis, and consider early surgical consultation if course is unfavorable or complicated. Consult for patients with malabsorption secondary to chronic pancreatitis.

9. Diagnose ascites by history, examination, laboratory and paracentesis if qualified. Paracentesis should be done in new onset ascites, fever, altered mental status, or changing

clinical course. Refer if paracentesis fluid is an exudate, chylous, intractable or if the diagnosis remains in question. Treat with diet and diuretics.

10. Resuscitate for acute upper GI and lower intestinal bleeding and refer immediately for consultation with gastroenterology and perhaps general surgery.

11. Manage stable inflammatory bowel disease with appropriate medications. Consultation is appropriate for the initial diagnosis, colonoscopy if indicated, or if control is not well maintained. Consult for acute exacerbation of inflammatory bowel disease.

12. Screen for colon cancer according to a recommended schedule. Guidelines for usual risk patients include an annual digital rectal exam after age 40 or 50, annual fecal occult blood test after age 50, and flexible sigmoidoscopy every three to five years after age 50. In testing for occult fecal blood, the dietary restriction should stress cooked vegetables, avoidance of red meat and non-steroidal anti-inflammatory drugs prior to testing. Earlier or more frequent examinations are indicated for high-risk patients. Consultation for colonoscopy is appropriate for a patient in whom an adequately done stool for occult blood test had been positive in the absence of obvious lower GI tract bleeding.

13. Screen for Hepatitis as appropriate. If referral for Hepatitis C is appropriate, see the attached guidelines.

14. **REFERRAL PROCESS**: Gastroenterology Clinic is twice monthly at SCHC with Drs. Blankenberg and Spinka

    Endoscopy referrals can be made directly to their office

    Hepatitis C Clinic is twice monthly at SCHC with Dr. Stanfield and Mr. Houston, Hepatitis C video is monthly and must be seen by patient prior to clinic appointment