Guidance for eReferral (reviewer-based) Services

Routine Consultation Requests

The goal of eReferral is to provide referring providers prompt access to specialty expertise and to optimize the use of scarce specialty resources. When you submit an eReferral, the reviewer may:

Schedule a routine or expedited clinic visit

Ask for clarification or additional information

Recommend additional diagnostic evaluation before scheduling a clinic visit or

Provide education and management without a visit

Because there is no direct contact with patients, the ability of the specialist reviewer to appropriately respond to your eReferral depends entirely on your providing accurate, relevant, and complete information about your patient's condition. **Please be explicit but succinct in stating your consultative question.**

After submitting an eReferral, you should receive a response by email within 3-5 business days. If this has not occurred, please contact the specialist reviewer (contact information on policy page).

Please note: You should not select someone other than yourself as the referring provider without their knowledge and consent.

Not scheduled eReferrals

If your patient is **not** scheduled for an appointment, you should receive an email notification alerting you to check your worklist. **As the referring provider, you are expected to read and respond to the specialist reviewer's response in a timely fashion.** The decision regarding whether a patient is scheduled in clinic is a mutual decision between the specialist reviewer and the referring provider based on discussion of the patient's case via eReferral. If you cannot come to an agreement with the specialist reviewer, please contact our eReferral program manager Tekeshe Mekonnen at MekonnenT@medsfgh.ucsf.edu.

Scheduled eReferrals

For appointments scheduled less than two weeks in advance, the specialty service will notify the patient by telephone. For all other appointments, the patient will receive an automated letter notifying her/him of the appointment. **Please verify the patient's phone number and address.** For homeless patients, please inform them that you have consulted your specialist colleague and that they should return to your clinic for appointment details, should a specialty clinic visit be advised.

If based on your knowledge of the patient's condition you think your patient requires a sooner appointment than has been scheduled, or if there are changes after submitting the initial request that may alter the patient's priority, please provide additional information by way of eReferral.

SFGH Otolaryngology-Head and Neck Surgery Clinic
Location: 4M
Link to ENT eReferral Guidelines

Monday morning

Wednesday afternoon

Thursday afternoon

Friday afternoon

The Department of Otolaryngology-Head and Neck Surgery provides care for patients afflicted by diseases that involve medicine and surgery of the head and neck.

Note: Treatment Guideline links below are to Adobe PDF Documents.

Appropriate referral includes but is not restricted to:

1. **NECK MASSES** or suspected **CANCER** of the head and neck

   CT with contrast of the neck

   Please see treatment guidelines Neck Mass Guideline 2008
2. **SALIVARY GLAND MASSES** or infection

   Please see treatment guidelines Salivary Gland Mass Guideline 2008
3. **THYROID MASSES**

   Your patient will be scheduled to be seen within 1-2 weeks.
4. **TONSILLITIS OR PERITONSILLAR ABSCESS**

   Please see treatment guidelines Tonsillitis and Peritonsillar Abscess Guideline 2008
5. **HOARSENESS** or **DYSPHAGIA**

   Please see treatment guidelines Voice Hoarseness and Dysphagia Guideline 2008
6. **FACIAL FRACTURES (nasal, jaw, cheek, orbital, sinus, temporal bone, larynx)**

   Please page the ENT resident on call in order to receive a priority appointment.
7. **HEARING LOSS**

   Please see treatment guidelines Hearing Loss Guideline 2008

   For cases of sudden hearing loss, please page the ENT resident on call to receive a priority appointment.
8. **OTITIS MEDIA**

   Please see treatment guidelines Otitis Media Guideline 2008
9. **VERTIGO**

   Please see treatment guidelines Vertigo Guideline 2008
10. **CHRONIC SINUSITIS, NASAL POLYPOSIS, OR SINUSITIS COMPLICATIONS**

CT scan without contrast of the paranasal sinuses

Please see treatment guidelines Sinusitis Guideline 2008

11. **EPISTAXIS**

    Please see treatment guideline Epistaxis Guideline 2008

12. **SLEEP APNEA** requiring surgical consideration

    Evaluation by Pulmonology Department

    Obtain Sleep Study

    Failed CPAP trial

    Please see treatment guidelines Obstructive Sleep Apnea Guideline 2008

13. **PEDIATRIC SLEEP APNEA**

    If this is due to a craniofacial abnormality, syndromal problem, or chronic debilitating disease, please refer for evaluation by UCSF Pediatric Pulmonology Department for pediatric sleep study.

    If none of the above situations apply, videotape of worrisome sleep habits of child by parents for review at ENT evaluation

14. **FACIAL COSMETIC SURGERY** including rhinoplasty, blepharoplasty, face lift, aging face surgery, facial resurfacing, scar revision, skin cancer excision and reconstruction, and trauma reconstruction of the nose and face.

NOTE: **imaging obtained at outside facilities MUST be brought in with the patient in the form of a CD or film along with the radiologist's written report.**

Directions for EMERGENCY CONSULTATION REQUEST:

For Emergency Consultation Requests **DO NOT SUBMIT AN ELECTRONIC REFERRAL**. Please page the Otolaryngology-Head and Neck Surgery resident at 415-443-0833.

Directions for Routine Consultation Requests:

Please follow the directions provided by this automated system. One of the main goals of the eReferral is to optimize the allocation of Otolaryngology-Head and Neck Surgery clinic appointments in order to benefit the maximum number of Community Health Network patients. We understand that you, as the patient's primary physician or health care provider, know the patient best. *The ability of our service to appropriately respond to your eReferral request depends on the accuracy and completeness of the information that you provide.*

eReferral Response:

After submitting an eReferral, you will receive a response by email within 5 business days. If this has not occurred, please contact the clinic reviewer, Christina Biondolillo, NP, at cherrera@ohns.ucsf.edu . The supervising attending is Dr. Andrew Murr, ahmurr@ohns.ucsf.edu . For appointments scheduled less than two weeks in advance, the Otolaryngology-Head and Neck Surgery clinic staff will notify the patient by telephone. Please be sure to verify the patient's current telephone number or other contact information. All other Otolaryngology-Head and Neck Surgery appointment notification is the responsibility of the

referring clinic.

If based on your knowledge of the patient's condition you think your patient requires a higher priority than indicated by our response or if you learn of additional information after submitting the initial request that may alter the patient's priority, please provide additional information by way of this eReferral process. Please be advised that the eReferral request and response to not represent a consultative opinion.

Neck Mass

Differential Diagnosis

Congenital Anomalies (cysts, sinuses, fistulae, lymphangiomas, or dermoids)

Inflammatory or Infectious Conditions (cervical adenitis, neck abscess, mycobacterial infections, HIV, cat-scratch disease, toxoplasmosis, infectious mononucleosis, or fungal infections)

Metabolic, Idiopathic and Autoimmune Conditions (gout, tumoral calcium pyrophosphate dehydrate deposition, inflammatory pseudotumor, Kimura's disease, Castleman's disease, or sarcoidosis)

Neoplasm (lipomas, hemangiomas, neuromas, fibromas, squamous cell carcinoma, thyroid cancer, salivary gland cancer, lymphomas, or sarcomas)

Pre-referral Checklist

History and Physical

Assess for the size and duration of mass, URI symptoms, sore throat, dysphagia, voice changes or hoarseness, recent travel or trauma, previous radiation therapy, otalgia, odynophagia, persistent oral ulcers, history of unilateral serous otitis, **smoking history, and alcohol use** history.

Skin inspection, palpation of neck upon rest, swallowing, and rotation of head, otologic examination, inspection and palpation of mucosal surfaces for any ulcerations, asymmetry, or submucosal swelling, measurement of any masses found.

Testing

CT scan of the neck with contrast

Possible FNA for palpable masses

Indications for Referral to ENT

Any unexplained neck masses. (Your patients will be scheduled to be seen within 1-2 weeks.)

Treatment Provided by ENT

For suspected infectious conditions: antibiotics and/or incision and drainage

For all other masses: triple endoscopy and biopsy with appropriate treatment modalities based on the pathology findings

References:

Schwetschenau, E. & Kelley, D. J. (2002). The Adult Neck Mass. *American Family Physician*, 66(5), 831-838.

Salivary Gland Mass

Differential Diagnosis

Infectious or Inflammatory Conditions (sialadenitis)

Metabolic/Secretory Disorders (sialadenosis)

Functional Conditions (sialolithiasis or sialectasis)

Cystic Conditions (mucoceles, duct cysts, ranula, or lymphoepithelial cysts)

Neoplasm (pleomorphic adenoma, Warthin's tumor, basal cell adenoma, oncocytoma, benign and malignant mesenchymal neoplasms, adenoid cystic carcinoma, acinic cell carcinoma, adenocarcinoma, squamous cell carcinoma, or mucoepidermoid carcinoma)

Pre-referral Checklist

History and Physical

Assess for the size and duration of mass, presence and timing of any pain, fever, xerostomia, absence/ slowing down of salivary flow, otalgia, dysphagia, frequency of symptoms, previous radiation therapy, smoking/tobacco history, and any history of HIV, Sjogren's syndrome, cystic fibrosis, sarcoidosis, malnutrition, vitamin deficiencies, and/or use of medications with sympathetic or parasympathetic effects.

Skin inspection, inspection and palpation of salivary glands and oral mucosal surfaces, attempted aspiration of pus from the affected duct, cranial nerve VII assessment, and otologic examination.

Treatment

o Please begin antibiotic coverage (Augmentin if not penicillin allergic) and promote hydration, use of sialagogues, glandular massage, and good oral hygiene while awaiting ENT appointment for patients with acute symptoms of fever, pain, and/or pus from their duct.

Testing

None at initial referral time but we may request you to order a CT of the neck/ salivary glands with contrast based on the information provided to us.

Indications for Referral to ENT

Any salivary gland mass.

References:

Seiden, A. M., Tami, T. A., Pensak, M. L., Cotton, R. T., and Gluckman, J. L. (2002). *Otolaryngology: The Essentials*. New York, NY: Thieme.

Tonsillitis

*Characteristics of **Acute Tonsillitis***

Fever above 38.5 C

Cervical adenopathy

Tonsillar exudate

Positive group A beta-hemolytic streptococcus (GABHS) throat culture

Indications for Referral to ENT (Recurrent Tonsillitis)

6 or more infections (see above criteria) during the last year; each treated with appropriate antibiotics

5 infections every year for the last 2 years; each treated with appropriate antibiotics

3 infections every year for 3 years; each treated with appropriate antibiotics

Chronic infections that have resulted in two weeks or more missed work/school in a year or in any speech delays

Treatment Provided by ENT

Patients with a history of tonsillitis that has not met the above frequency for referral to ENT are best treated by primary care providers with streptococcal directed antibiotics.

Once the above indications have been met, tonsillectomy is considered.

*Characteristics of **Chronic Tonsillitis***

The presence of **tonsilithiasis** (white, foul particles imbedded in tonsils)

Indications for Referral to ENT

Persistent tonsilithiasis and throat pain despite a 2 week course of antibiotics and Peridex gargles three times a day.

Treatment Provided by ENT

Tonsillectomy is considered after the above indications have been met.

*Characteristics of **Peritonsillar Abscess***

unilateral bulging tonsil

trismus

deviated uvula

severe dysphagia and throat pain

fever above 38.5 C

Please call the ENT clinic directly so your patient can be seen today. If the clinic is not open, please send your patient to the ED.

Treatment Provided by ENT

Incision and drainage or needle aspiration of their abscess with a course of antibiotics. If there has been more than one occurrence of peritonsillar abscess, tonsillectomy is recommended.

References:

Darrow, D. H. & Siemens, C. (2002). Indications for Tonsillectomy and Adenoidectomy. *The Laryngoscope*, 112, 6-10.

Carper, R. & Canter, R. J. (2001). How well do parents recognize the difference between tonsillitis and other sore throats? *Clinical Otolaryngology*, 26, 458-464.

Department of Otolaryngology- Head and Neck Surgery (ENT) Referral Guidelines 7/16/08

Voice Hoarseness and Dysphagia

Differential Diagnosis

Neoplasm (laryngeal papilloma, laryngeal squamous cell carcinoma, thyroid cancer, or mass lying anywhere along the recurrent laryngeal nerve)

Inflammatory or Infectious Conditions (granulomas, gastroesophageal reflux, reflux laryngitis, or laryngitis – viral, bacterial, fungal, or allergic)

Neurologic Conditions (unilateral vocal cord paralysis, spasmodic dysphonia, Parkinson's disease or other movement disorders, or CVA)

Miscellaneous (foreign body, vocal cord abuse, hypothyroidism, muscle tension dysphonia, or as a result of medications)

Pre-referral Checklist

History and Physical

Assess for any precipitating events (URI, exposure to irritants, recent strong voice use, choking on food), the patient's voice use pattern, pain, cough, shortness of breath, symptoms of reflux, allergic rhinitis, use of antihistamines and other medications that dry the upper airway mucosa, any recent unintentional weight loss, **smoking history, and alcohol use** history

Full head and neck exam, including cranial nerve assessment, visualization of the oropharynx, and palpation of the base of tongue.

Testing

None at time of referral but we may request certain testing on a case by case basis.

If there are no risk factors for cancer present and you have a high suspicion for reflux, please order a modified barium swallow.

Indications for Referral to ENT

Any high suspicion of cancers of the mouth, pharynx, or larynx, or suspected foreign bodies. (These patients will receive a priority appointment within 2 weeks.)

Any unexplained voice hoarseness persisting beyond 2 weeks.

References:

Rosen, C. A., Anderson, D., & Thomas, M. (1998). Evaluating Hoarseness: Keeping Your Patient's Voice Healthy. *American Family Physician*, 57, 2775-2782.

Hearing Loss

Differential Diagnosis (Conductive Hearing Loss)

Cerumen impaction

Otitis externa

Tympanic membrane perforation

Otitis media with effusion

Ossicular chain abnormality

Cholesteotoma

Differential Diagnosis (Sensorineural Hearing Loss)

Presbycusis

Noise exposure

Familial/Genetic conditions

Ototoxic medications

Infectious/Post-inflammatory conditions

Acoustic Neuroma

Pre-referral Checklist

History and Physical

Assess the onset and duration of the hearing loss, whether it is bilateral or unilateral, if it is associated with otalgia, tinnitus, ear fullness, or vertigo. Ask about any history of ear infections, ear surgery, ear discharge, trauma, noise exposure, use of ototoxic medications, and/or family history of early hearing loss.

Otoscopic examination of the bilateral ear canals and tympanic membranes with insufflator and Weber and Rinne tests.

Testing

Audiogram and Tympanogram (We will schedule your patient's audiology exam as well as their follow-up ENT appointment on the same day, IF POSSIBLE.)

Any other testing, such as an MRI with GAD of the cerebellopontine angle or CT scan without contrast of the temporal bone, will be determined and ordered by ENT based on our initial exam findings and results of the audiogram.

Indications for E-Referral to ENT

Any suspected hearing loss not attributed to:

Cerumen impaction. (If your exam reveals cerumen impaction and your patient has no history of previous ear perforations, begin Debrox drops in the affected ear[s] daily for two weeks and see the patient back. If the wax persists, please submit an ENT e-referral.)

Recent otitis media. (The natural history of otitis media is that it resolves in 90% of cases within three months. If it persists beyond this point, please submit an ENT e-referral.)

Indications for Calling ENT Clinic directly/ Paging ENT

Any sudden hearing loss.

References:

Wax, M. K. (Ed.). (2004). Hearing Loss. In, *Primary Care Otolaryngology* (p. 33-39). Alexandria, VA: American Academy of Otolaryngology—Head and Neck Surgery, Inc.

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Otitis Media

Characteristics of Acute Otitis Media

Bulging of the tympanic membrane

Limited/Absent tympanic membrane mobility

Observed fluid behind the tympanic membrane

Otorrhea

Distinct tympanic membrane erythema or distinct otalgia

Temperature ≥ 39°C

Pre-referral Checklist

History and Physical

Confirm the presence of the above characteristics or symptoms.

Otoscopic examination of bilateral ear canals and tympanic membranes

Palpation of tragus on affected ear side

Visualization of throat and nose

Palpation for cervical lymph adenopathy

Assess for the onset and duration of symptoms

§ Treatment

2 week course of antibiotics directed at the most common otitis media pathogens (Streptococcus pneumoniae, non-typeable H influenzae, and M catarrhalis).

Indications for Referral to ENT

Any treated otitis media patient with symptoms persisting beyond 3 months. (The natural history of otitis media is that it typically resolves in 90% of cases within 3 months. If it persists beyond this point, please refer your patient.)

Documented history of 5-6 treated otitis media infections in the last year.

Any patient with a tympanic membrane perforation.

**Please note that if the above indications apply, we will schedule your patient for an audiogram prior to their appointment with us. We will schedule these two appointments for the same day, IF POSSIBLE.*

Treatment Provided by ENT

Myringotomy with or without insertion of pressure equalization tube for chronic otitis media with effusion.

Tympanoplasty with or without mastoidectomy for tympanic membrane perforations.

References:

University of Michigan Health System. (2007). Otitis Media. Retrieved May 13, 2008, from National

Guideline Clearinghouse database.

SFGH Endocrinology Clinic
Location: Ward 92

Monday and Thursday Mornings

Appropriate referrals and required tests include, but are not restricted to:

15. Thyroid nodule(s) for evaluation/biopsy (TSH, FT4 required, ultrasound or nuclear medicine scan NOT REQUIRED)
16. Thyroid dysfunction or thyroid cancer (TSH, FT4 required)
17. Calcium/Vitamin D disorders (Ca++, Albumin, PO4, PTH, 25-OH Vitamin D required)
18. Adrenal or pituitary disorders
19. Osteoporosis/Osteopenia (DEXA, loss of height, kyphosis or osteopenia on plain films required)
20. Gonadal disorders such as amenorrhea or male hypogonadism.
21. Disorders of water or electrolyte (K+, Na+) balance
22. Suspected endocrine hypertension (e.g. pheochromocytoma, hyperaldosteronism)
23. Endocrine tumors (e.g. incidentally discovered adrenal or pituitary masses)
24. Familial, genetic, or autoimmune endocrine disorders

Directions for Emergency Consultation Requests: For urgent consultative requests **DO NOT SUBMIT AN ELECTRONIC REFERRAL.** Please page the endocrine fellow at 415-443-9535.

Directions for Routine Consultation Requests: Please follow the directions provided by this automated system. One of the main goals of the eReferral is to optimize the allocation of Endocrine Clinic appointments in order to benefit the maximum number of Community Health Network patients. The Endocrine Service recognizes that you, as the patient's primary care provider, know the patient best. *The ability of the Endocrine Service to appropriately respond to your eReferral request depends on the accuracy and completeness of the information that you provide.*

eReferral Response: After submitting an eReferral, you will receive a response by email within 5 business days. If this has not occurred, please contact the physician reviewer Dr. Lisa Murphy at emurphy@medsfgh.ucsf.edu . Your patient will receive an appointment reminder letter two weeks before his/her scheduled appointment. For appointments scheduled less than two weeks in advance, the Endocrine Clinic will notify the patient by telephone. For all other appointments, the patient will receive an automated letter notifying her/him of the appointment. **Please verify the patient's phone number and address.**

If based on your knowledge of the patient's condition you think your patient requires a higher priority than indicated by our response, or if you learn of additional information after submitting the initial request that may alter the patient's priority, please provide additional information by way of this eReferral process. Please be advised that the eReferral request and response do not represent a consultative opinion.

Electronic Referral (eReferral) for SFGH Cardiology Clinic
Location: 1M3

Monday, Tuesday, Wednesday, and Friday Mornings

Appropriate referrals include, but are not restricted to:

1. Positive stress tests suggestive of coronary artery disease
2. Heart failure refractory to standard medical therapy
3. Arrhythmias, pacemakers, and defibrillators
4. Acquired valve disease with increasing symptoms
5. Adults with congenital heart disease
6. Cardiac patients scheduled for major surgery
7. Evaluation and management of patients with a diagnosis of pulmonary hypertension or evidence of elevated pulmonary artery pressure or right heart failure on echocardiogram
8. Initiation or ongoing management of pulmonary hypertension specific therapy such as sildenafil

The following tests are required prior to all Cardiology Clinic appointments:

1. CBC
2. Electrolytes and creatinine
3. Fasting lipid panel
4. TSH
5. Hemoglobin A_{1C} for diabetics

For patients referred for evaluation and management of pulmonary hypertension, consider ordering:

Echocardiogram

Pulmonary function tests

High resolution CT scan

Liver ultrasound

V/Q scan

Blood for arterial blood gas

ANA

Rheumatoid factor

HIV

Hepatitis serologies

Directions for Emergency Consultation Requests:

For emergency consultative requests **DO NOT SUBMIT AN ELECTRONIC REFERRAL**.

Please ask the SFGH operator (415-206-8000) to page the cardiology consult fellow for an emergency consultation, or page the consult fellow directly at 415-443-1440.

Directions for Routine Consultation Requests:

Please follow the directions provided by this automated system. One of the main goals of the eReferral is to optimize the allocation of Cardiology Clinic appointments in order to benefit the maximum number of Community Health Network patients. The Cardiology Clinic recognizes that you, as the patient's primary care provider, know the patient best. *The ability of the Cardiology Clinic to appropriately respond to your eReferral request depends on the accuracy and completeness of the information you provide.*

eReferral Response: After submitting an eReferral, you will receive a response by email within 5 business days. If this has not occurred, please contact Dr. Mary Gray at mgray@medsfgh.ucsf.edu. For appointments scheduled less than two weeks in advance, the Cardiology Clinic will notify the patient by telephone. For all other appointments, the patient will receive an automated letter notifying her/him of the appointment. **Please verify the patient's phone number and address.**

If based on your knowledge of the patient's condition you think your patient requires a higher priority than indicated by our response or if you learn of additional information after submitting the initial request that may alter the patient's priority, please provide additional information by way of this eReferral process. Please be advised that the eReferral request and response do not represent a consultative opinion.

Electronic Referral (eReferral) for
SFGH Gastroenterology Clinic
Location: 3D

For clinic information, including hours of operation, please visit:
SFGH Ambulatory Services-GI Clinic

Appropriate referrals and required tests include, but are not restricted to:

- Proven iron deficiency anemia
- Persistent nausea and vomiting, diarrhea, or constipation
- Gross or occult gastrointestinal bleeding
- Refractory or severe abdominal pain, dyspepsia, or non-cardiac chest pain
- Personal or family history of or strong history of colon cancer
- Dysphagia or odynophagia
- Inflammatory bowel disease
- Biliary or pancreatic disease

If you are referring a patient for consideration of an endoscopic procedure, please include the following information:

- History of cardiac or pulmonary disease, including CO_2 retention or home oxygen use
- Chronic and active alcohol, sedative, or narcotic use
- Known abnormalities of the oropharynx, pharynx, or neck
- Known coagulopathy (INR >1.2 or platelet <75) or severe anemia (Hct<30)

Inpatient Policy:
The GI Clinic **DOES NOT** accept referrals from inpatient services. If you have a hospitalized patient requiring an inpatient GI evaluation, please page the on-call GI fellow to request a consultation. If this is in regards to a patient already seen by the inpatient GI consult service, please contact the fellow who saw the patient, or, if that person is unavailable, the on-call GI fellow. If your patient was not seen by the inpatient GI service and requires an ambulatory GI evaluation, please discuss with the patient's PCP and ask them to refer the patient if appropriate.

eReferral Response:
After submitting an eReferral, you will receive an automated email within 5 business days about the status of your eReferral. If your patient has been **scheduled**, the email will contain the date and time of the appointment. If your patient has **not been scheduled**, the specialist reviewer likely needs additional information from you; the email will ask you to check your eReferral worklist.

If you did not receive an email within 5 days, please contact the specialty reviewer, **Dr. Justin Sewell** at **Justin.Sewell@ucsf.edu.**

For appointments scheduled less than two weeks in advance, the GI clinic will notify the patient by telephone. For all other appointments, the patient will receive an automated letter notifying him/her of

the appointment. **Please verify the patient's phone number and address is up-to-date in the LCR.**

PLEASE NOTE: The specialist's eReferral response is based on the clinical information you have provided, without the benefit of a comprehensive evaluation or physical examination. The ability of the specialist reviewer to appropriately respond to your eReferral depends on your providing accurate, relevant and complete information about your patient's condition.

If based on your knowledge of the patient's condition you think your patient needs to be scheduled for a clinic visit, or requires an appointment sooner than has been scheduled, please provide additional information using the eReferral program.

Electronic Referral (eReferral) for
SFGH Urology Clinic
Location: 3M

Tuesday and Friday Mornings 8:30-12:00

Please refer to treatment guidelines that are linked to this page.

Appropriate referral and required tests include, but are not restricted to the following:

- Gross and Microscopic Hematuria

  Please see treatment guidelines Guidelines Gross Hematuria 2013

  Prior to referral, patient must have

  either CT adb/pelvis with

  - non-contrast
  - IV contrast **and**
  - 10 minute delayed scans

  or Renal U/S if Cr > 1.4 mg/dl

- Nephrolithiasis

  Please obtain CT Stone Protocol (non-contrast) **and** KUB prior to referral

- Genitourinary Cancer

  Please see treatment guidelines Guidelines Prostate Ca Screen-Transrecta 2013 and Guidelines Renal or Adrenal Mass 2013

  The patient must bring prior records and films if work up has already been initiated at an outside hospital

- Benign Prostate Hypertrophy

  Please see treatment guidelines Guidelines Male Lower UT Symp 2013

  Patient must have failed trial of alpha blocker with titration to maximal dose (e.g. terazosin 10 mg/nightly). If not, please provide explanation of why medication not started or dose not maximized.

- Impotence

  Please see treatment guidelines Guidelines Erectile Dysfunction 2013

  Primary care providers are responsible for initial trial of PDE inhibitor (ie, Viagra) use if indicated. If patient has not been tried on a PDE inhibitor then provide explanation.

- Scrotal Mass

  Please see treatment guidelines Guidelines Suspected Testicular Mass 2013

Imaging obtained at outside facilities must be brought by the patient in the form of a CD or film along with a radiologist's written report. Referrals will NOT be seen until ordered radiographic test have been COMPLETED.

Directions for Urgent Consultation Requests: DO NOT SUBMIT AN ELECTRONIC REFERRAL. Please contact the hospital operator at 206-8000 and page the Urology resident on call.

Directions for Routine Consultation Requests: Please follow the directions provided by this automated system. One of the main goals of the eReferral is to optimize the allocation of Urology Clinic appointments in order to benefit the maximum number of Community Health Network patients. *The ability of the Urology service to accurately respond to your eReferral request depends on the precision and completeness of the information that you provide.*

eReferral Response: After submitting an eReferral, you will receive a response by email within 5 business days. If this has not occurred, please contact the clinic reviewer, Benjamin Breyer, MD at bbreyer@urology.ucsf.edu. All patients will receive an automated appointment notification letter when the appointment is scheduled. For appointments scheduled less than two weeks in advance, the Urology Clinic will also notify the patient by telephone. For appointments scheduled more than two weeks out your patient will receive an additional appointment reminder letter two weeks before his/her appointment date. **Please verify the patient's phone number and address.**

If based on your knowledge of the patient's condition you think your patient requires a higher priority than indicated by our response or if you learn of additional information after submitting the initial request that may alter the patient's priority, please provide additional information by way of this eReferral process. Please be advised that the eReferral request and response do not represent a consultative opinion.

CHN Urology Referral Guidelines 12/12/13

Painless Gross Hematuria (GH): Painless GH is defined as the presence of blood in urine that is clearly visible by the eye without the use of any magnification tools. Painless GH raises concern for bladder cancer.

Indications for Referral to SFGH Urology

- Refer to urology. All patients with GH will be scheduled for a urology appointment within two weeks unless they have an obvious urinary tract infection. As stated above, a U/A to confirm that there is no microhematuria after infection is cleared is necessary.
- Schedule for CT Urogram (abdominal and pelvic CT scan w/ and w/o contrast with delayed images to visualize the collecting systems and ureters).

Differential Diagnosis

- Food dye, beets
- Urinary tract infection
- Cancer: renal, urinary tract, bladder, prostate
- Nephrolithiasis
- Intrinsic Renal Disease: IgA nephropathy, benign familial hematuria, glomerulonephritis, interstitial nephritis, polycystic kidney disease, Alport's
- Medication: NSAIDS, coumadin, gold, rifampin
- Trauma
- Papilary necrosis with sickle cell trait and disease.
- Menstruation
- Systematic disease: SLE, endocarditis, rheutmatic fever, autoimmune (Wegners, Goodpastures, Polyarteritis Nodosa)

Pre-referral Checklist (recommended)

- Physical exam
  - Prostate exam for nodules, induration, tenderness
  - Abdominal exam, suprapubic palpation for bladder distention
  - Vital signs to rule out symptomatic anemia
  - Costo vertebral angle tenderness (CVAT)

- Testing
  - CBC with differential
  - Urine culture to rule out infection if dysuria present (If infection is present, UA must be repeated after infection is clear to demonstrate complete resolution of hematuria.)
  - BUN and creatinine to help rule out ureteral obstruction
  - CT scan of abd/pelvis with 1) non-contrast 2) contrast and 3) delayed images to rule out upper and lower tract stones and malignancy. Ordering a CT scan should not delay the referral to urology, but it will be required as part of the work-up

CHN Urology Referral Guidelines 12/12/13

There are multiple conflicting recommendations regarding prostate cancer screening. For example, the USPSTF recommends against screening altogether, whereas the American Cancer Society and the American Urologic Association recommend screening.

If you choose to screen:

 The American Urological Association recommends annual digital rectal examination and shared decisionmaking for men age 55 to 69 years who are considering PSA screening, and proceeding based on a man's values and preferences.

 To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening.

 For men younger than age 55 years at higher risk (e.g. positive family history or African American race), decisions regarding prostate cancer screening should be individualized based on personal preferences and an informed discussion regarding the uncertainty of benefit and the associated harms of screening.

Indications for Referral to SFGH Urology

- Elevated PSA > 4 mg/ml in the absence of infection
- Digital rectal examination with clear nodule or area of induration (even with a normal PSA)

Differential Diagnosis – Elevated PSA

- Lab error
- Benign Prostatic Hypertrophy (BPH)
- Inflammation or Infection
- Prostate Cancer

Pre-referral Screening Checklist (recommended)

- History and physical exam
  - Check for symptoms of urinary tract infection or prostatitis
  - Abdominal exam for suprapubic pain
  - Prostate exam for nodules, induration, tenderness
- Testing
  - If there is a suggestion of UTI, send UA with micro and culture
  - PSA after discussion with patient
  - If active UTI then treat and re-check PSA two weeks later.

Goals for Urology Appointment

- Clinic visit within two to three weeks' time
- Prostate biopsy within six weeks from referral

Transrectal ultrasound guided biopsy is an outpatient procedure performed in a urologist's office. At SFGH, biopsies are performed in a minor procedures area. The biopsy takes about 15 minutes. With current use of injectable lidocaine, the overwhelming majority of patients tolerate

the procedure well. Some side effects of prostate biopsy include hematuria, hematochezia, hematospermia, and urinary retention (approximately 5%). These are usually self-limited to approximately one week's time.

Prostate Cancer Diagnosis and Treatment

Led in large part by data from UCSF, there is an increasing trend toward risk stratification in the diagnosis and treatment of prostate cancer, with a move toward active surveillance in men with low grade (Gleason 6) and low volume (few positive biopsy cores) prostate cancer, and a move toward more aggressive treatment of men with high grade (Gleason 7 or >) or high volume tumors. PSA testing continues to be the best tool for identifying high grade cancers when they are still organ-confined, and for this reason we strongly encourage primary care physicians to discuss the pros/cons of the test with male patients age 55-69 years with at least a 10-15 year life expectancy.

CHN Urology Referral Guidelines 12/12/13

Renal or Adrenal Mass

Indications for Referral to Urology

- All patients with solid renal or adrenal masses discovered on imaging procedures should be referred immediately to Urology Clinic for evaluation.

Referral Guidelines 12/12/13

Male Lower Urinary Tract Symptoms (LUTS)-Term that includes all storage/voiding disturbances in men secondary to

- **Structural abnormality of the bladder, bladder neck, prostate (BPH), distal sphincter mechanism, and urethra**
- **Abnormalities of peripheral or central nervous system, cardiovascular, respiratory, or renal disease**

Indications for Referral to Urology

- Elevated PSA (important: 5-alpha reductase inhibitors reduce PSA by 50% after 6 months of treatment, so PSA should be doubled for comparison to untreated patients)
- Prostate exam suspicious for prostate cancer
- History of hematuria
- History/risk of urethral stricture
- Continued bothersome symptoms after adequate therapeutic trial (see above)
- Ureteral obstruction on ultrasound or CT
- Palpable bladder or elevated post-void residual (> 100 ml)
- History of prior urogenital surgery, or diagnosis of neurogenic causes of bladder dysfunction

Differential Diagnosis

- BPH
- Prostatitis/UTI
- Prostate cancer
- Overactive bladder syndrome - urgency w/ or w/o urge incontinence, hypodynamic detrusor with overflow symptoms
- Drug-induced urinary dysfunction (anticholinergics, sympathomimetics, etc.)
- Bladder neck contracture or urethral stricture (other forms of bladder outlet obstruction (BOO)

Pre-referral Checklist (recommended)

- Physical exam
  - Prostate exam for nodules, induration, tenderness
  - Abdominal exam for distended bladder, masses
  - Neurologic assessment, rectal tone, gross motor exam and perineal sensation

- Testing
  - AUA Symptom Index (AUA-SI)
    http://cpsc.acponline.org/enhancements/238BPHSymptomCalc.html
- Assess severity of the disease
  - BPH Impact Index (BII)
    - Assess the effect of symptoms on everyday life
    - Patients w/ BPH and mild LUTS that are not bothersome should not be treated
  - Urinalysis to rule out pyuria, hematuria, glycosuria
  - BUN/creatinine measurement is ***not*** indicated in the initial evaluation of men with LUTS secondary to BPH
  - PSA (given symptoms, not considered screening)
- Watchful Waiting/Active Survillence – Appropriate for patients w/ mild LUTS (AUA-SI <8) or with moderate or severe symptoms (AUA-SI≥8) who are not bothered by their LUTS
- Therapeutic trial
  - Alpha-blocker - reassess after 2-4 weeks of medical therapy
    - Tamsulosin preferred if on formulary, given better side effect profile and little need for titration. Start at 0.4 mg nightly and increase to 0.8 mg after 2 weeks if necessary.
    - Terazosin start at 2mg nightly, increase q 1-2 weeks prn symptoms to maximum dose of 10mg nightly. Titration limited by orthostasis, dizziness, lightheadedness, and fatigue.
    - Intraoperative floppy iris syndrome (IFIS) – Men with planned cataract surgery should not be started on alpha blocker until after surgery
  - 5-alpha reductase inhibitor - reassess after 3 months of medical therapy
    - Indication: demonstratable prostatic enlargement and LUTS
    - Trial of finasteride 5mg daily or dutasteride 0.5mg daily combination therapy with alpha-blocker only if inadequate response to maximal tolerated dose of alpha-blocker alone.

CHN Urology Referral Guidelines 12/12/13

Erectile Dysfunction (ED): Diagnosis requires at least 3 months of consistent or recurrent inability to attain and/or maintain penile erection sufficient for sexual activity

Indications for Referral to Urology

- Treatment failure with PDE-5, intolerance of side effects, or unwillingness to use
- Interest in injection therapy
- Peyronie's disease
- Hypogonadism

Evaluation/Differential Diagnosis

- Obtain sexual, medical, and psychosocial history

- Assess the duration of ED and concomitant medical and psychosocial factors
- Frequent comorbidities – DM, depression, and alcoholism, cardiovascular disease (HTN, atherosclerosis, or hyperlipidemia),
- Erectile dysfunction may be considered as additional cardiovascular risk factor in targeting lipid levels
- Risk factors – smoking, history of pelvic, perineal, or penile trauma or surgery, neurologic disease, endocrinopathy, obesity, history of pelvic radiation, Peyronie's disease, and prescription or recreational drug use
- Contraindications to medical treatment of ED may also be identified during the history
- Look for reversible causes:
- Psychogenic - sexual history, interpersonal stress, depression

Drugs: Spironolactone, sympathetic agonists (e.g., clonidine), thiazide diuretics, SSRIs, ketoconazole, cimetidine, opiates

Pre-referral Checklist (recommended)

- Physical exam
    - Genital examination including search for penile plaques (calcification under the skin), testicular size (small size suggests hypogonadism)
    - Femoral and peripheral pulses
- Testing
    - Utility of serum testosterone level controversial
- Ensure optimal management of DM, heart disease, and HTN
- Therapeutic trial
    - Phosphodiesterase type 5 inhibitor (PDE-5) (see table below)
    - Counseling on PDE-5 use
- Empty stomach
- 1 hr before intercourse
- Must have stimulation
    - Contraindicated in patients taking nitrates and those considered with high risk cardiovascular disease (unstable or refractory angina; uncontrolled hypertension; congestive heart failure (CHF); New York Heart Association class III, IV); MI or a cardiovascular accident within the previous 2 weeks; high-risk arrhythmias; hypertrophic obstructive and other cardiomyopathies; or moderate-to-severe valvular disease

CHN Urology Referral Guidelines 12/12/13

Suspected Testicular Mass

Indications for Referral to Urology

- Immediate referral to Urology (need not wait for ultrasound results) if mass is obviously intra-testicular and not an epididymal cyst. Page resident on-call to schedule.

- If ultrasound confirms benign scrotal process before patient is seen at Urology (i.e. hydrocele, spermatocele, varicocele, epididymal cyst), symptomatic patients may be referred for routine appointment, after a failed trial of non-steroidal medication and supportive underwear.

Differential Diagnosis

- Rule out testicular cancer
- Epididymal cyst
- Orchitis

Pre-referral Checklist (Recommended)

- Physical exam
  - External genitalia palpated for equal volume, tenderness, swelling, scrotal torsion
  - Lymph node survey
  - Palpate abdomen for masses
  - Chest auscultation clarifying mediastinal mass
- Testing
  - Urgent ultrasound: should be done ASAP within 1 week
  - Order AFP, □ HCG, LDH if mass is obviously intra-testicular