Referral criteria from Primary Health Care to Secondary or Tertiary Health Care for Non-Communicable Disease Patients

Directorate of Non Communicable Diseases
Ministry of Health

Referral criteria from Primary Health Care to Secondary or Tertiary Health Care for NCD patients

REFERRAL CRITERIA FROM PRIMARY CARE TO SECONDARY/ TERTIARY CARE

HYPERTENSION

1. Persistently raised BP ≥ 140/90 in people less than 40 years to exclude secondary causes of hypertension
2. Persistently raised BP ≥ 140/90 for any patient in spite of optimum treatment with the combination of 3 drugs including a diuretic (thiazides or thiazide like diuretics, calcium channel blockers, ACEIs**) (maximum recommended or tolerable doses)
3. Suspected secondary hypertension based on history and examination
4. HMOD: proteinuria, advanced hypertensive retinopathy, new-onset CVD, CKD etc.
5. Hypertension in young (age <40 years)
6. Suspected white-coat hypertension/ masked hypertension (when ABPM is required)
7. Resistant hypertension

HTN in pregnancy

1. Look for evidence of hypertension associated target organ damage and arrange appropriate referrals to specialist care for advice, if the woman is planning for pregnancy.
2. Early medical referral should be done, if blood pressure remains poorly controlled especially in gestational hypertension or preeclampsia.

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DIABETES

Referral For DIABETES PATIENTS

1. DM with two consecutive fasting blood glucose> 7.2 mmol/L (130 mg/dL) (? 126 ask the endocrinologist) despite good compliance with lifestyle modification and drug therapy with maximum tolerated doses of metformin + sulphonyl urea
2. DM with foot ulcers
3. DM with recent deterioration of vision or no eye examination in past 2 years

Referral Of DIABETIC PATIENTS TO EYE UNIT

1. Snellen's visual acuity (with pin hole) of 6/12 or worse / recent visual symptoms - refer within a month
2. diabetic patients with poor glycaemic control and/ or those with co morbidities (renal disease, hypertension, abnormal lipids, anaemia, pregnancy) who have not undergone eye screening within the last 1 year
3. uncomplicated patients who have not undergone eye screening within the last 2 years
4. Those with Diabetic retinopathy changes seen with direct ophthalmoscope

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Referral For NEUROPATHIES

1. Atypical Clinical features
2. Motor symptoms >Sensory symptoms
3. Rapid Onset of symptoms
4. Asymmetrical presentation
5. Unclear diagnosis
6. Possibility of differential aetiology
7. A referral to a pain clinic is suggested for patients whose pain is unresponsive to conventional therapies.
8. In patients with severe and chronic pain tramadol or tapentadol may be used as the "last-line" therapy for a short duration prior referral to a pain clinic.

Referral For NEPHROPATHIES

1. A referral to a nephrologist should be done before discontinuing contraception, if the urinary protein: creatinine ratio is greater than 30 mg/ Cr mmol or serum creatinine is elevated above normal and/ or the estimated glomerular filtration rate (eGFR) is less than 45 ml/minute/1.73 m

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DYSLIPIDEMIA

1. If target LDL level not achieved with maximum dose of a statin (atorvastatin 40mg) despite adherence to the drug and lifestyle modification after 3 months
2. If patient develops statin Associated Side Effects (SASE)
3. High TG levels >500
4. Pregnancy
5. Total cholesterol ≥ 7mmol/L (270mg/dL) in individuals less than 35 years (why not in older to rule out primary or secondary aetiology)

CARDIOVASCULAR DISEASES (CVD)

1. Known heart disease, stroke, TIA, PVD or kidney disease who are not being followed up by specialist clinic (this is to obtain a plan of management which can be continued at the primary level
2. Angina, shortness of breath on exertion, Intermittent claudication
3. Proteinuria (confirmed on two tests)

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CHRONIC RESPIRATORY DISEASES (CRD)

ASTHMA

1. Systemic features (low grade fever, loss of appetite, loss of weight, clubbing)
2. Pregnancy
3. Poorly controlled Asthma

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

1. Patient with two or more exacerbations per year (increased intensity of symptoms SOB, sputum production and wheezing needing treatment)
2. Resting saturation <90% on air
3. Patients with clinical evidence of cor -pulmonale (elevated JVP, bilateral ankle oedema and loud P2)
4. Patients with finger clubbing
5. Persistent crepitations despite treatment

BRONCHIECTASIS

1. Early referral – difficult to walk for about 15 min at a stretch or about 100m at own pace.
2. Recurrent exacerbations
3. Cor – pulmonale
4. Routine referral – other patients with suspected bronchiectasis may be referred to a consultant unit on a routine basis.

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CRITERIA FOR IMMEDIATE REFERRAL FOR SPECIALIST CARE

HYPERTENSION

- Hypertensive emergency: An elevated SBP ≥180 mmHg and/or DBP ≥120 mmHg, with evidence of acute HMOD. Parenteral treatment is recommended for management of hypertensive emergencies.

DIABETIC NEUROPATHY

- Acute foot problems should be attended to within 24 hours of referral.

DIABETIC RETINOPATHY

- Sudden loss of vision in one or both eyes
- Noticing of sudden floaters or flashing lights (can indicate bleeding)
- Severe pain or headache following dilation of pupils (can indicate an angle - closure attack)
- Swollen optic discs (may indicate diabetic papillopathy)
- Severely disorganised retinal findings (large Haemorrhages, fibrosis)

BRONCHIECTASIS

- Haemoptysis