Hypertension Referral Guideline

Department of Health clinical urgency categories for specialist clinics

For all emergency cases that require immediate review, or pose an immediate risk to life or limb, please dial 000 or send the patient to the Emergency Department.

Direct the patient to the Emergency Department for the following reasons:

- Hypertensive emergency (blood pressure > 220/140)
- Severe hypertension with systolic blood pressure > 180 mmHg with any of the following:
  - headache
  - confusion
  - blurred vision
  - retinal haemorrhage
  - reduced level of consciousness
  - seizure(s)
  - proteinuria
  - papilloedema
- A pregnant woman with pre-eclampsia with uncontrolled severe hypertension (i.e. diastolic blood pressure > 110 mmHg or systolic blood pressure > 170 mmHg).

Urgent: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt.

Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.

Exclusions: The Clinical Pharmacology Unit does not provide the following services:

- **The care of paediatric patients**

Condition / Symptom	Criteria for Referral	Information that must be included	Information to be provided if available	Expected Triage Outcome	Austin Specific Notes
Hypertension	• Severe persistent hypertension > 180/110 • Refractory hypertension (blood pressure > 140/90) in patients: ○ taking three or more antihypertensive medicines	• Meets Austin Health minimum referral information • Blood pressure measurements, preferably taken on both arms on 2 occasions • Details of all relevant signs and symptoms	• History of smoking and alcohol intake • Liver function tests • Full blood examination results • Fasting lipid profile results • Estimated glomerular filtration rate (eGFR)	**Urgent** if early onset hypertension or severe persistent hypertension **Semi-urgent** if uncontrolled hypertension with other comorbidities where hypertension control is an important	Patients without a recent ambulatory blood pressure monitor may be triaged to have this performed at their first appointment with the clinic.

Commented [WI1]: This is taken from the VIC government Statewide specialist referral criteria guidelines: https://src.health.vic.gov.au/hypertension

Commented [WI9]: https://www.austin.org.au/minimum-referral-information/

	○ unable to tolerate maximum treatment. ○ Side effects with 2 or more different classes of anti-hypertensives, necessitating drug cessation, with suboptimal control on existing treatment • Early onset hypertension (<40 years) • Pre or early conception HTN medication advice or upon referral from obstetric medicine. • Exemptions may be made for certain clinical scenarios after discussion with clinical pharmacology **Referral not appropriate for:** • New diagnosis of hypertension with no medical management (unless early onset hypertension or suspected secondary hypertension) • Controlled hypertension on <3 medications. • Isolated episode of hypertension • Pregnant patients under the care of an obstetrician should be referred to obstetric medicine. Referrals from	• Relevant medical history and comorbidities • Any treatments previously tried, duration of trial and effect • Current and complete medication history (including non-prescription medicines, herbs and supplements and recreational or injectable drugs). • Correspondence or information from previous hypertension specialists if available	• Urinalysis results • Fasting glucose and HbA1c% • Secondary screen if previously performed i.e. plasma or urine metanephrines, renin, aldosterone, renin-aldosterone ratio, 8am cortisol, thyroid function results • Urine protein test results • Renal artery duplex report (if renal artery stenosis is suspected and report is available) • Previous 12 lead electrocardiogram (ECG) tracings • Echocardiogram report • If the person is pregnant or planning pregnancy • If the person identifies as an Aboriginal and Torres Strait Islander. • Height and weight	primary or secondary prevention parameter Otherwise, **routine**	

Commented [WI2]: Statewide hypertension referral criteria. I believe being unable to tolerate maximum treatment would cover the patients with medication intolerances.

Commented [AF3R2]: Agreed

Commented [WI4]: Me based on some of the stuff we see

Commented [AF5R4]: Agreed.
How about an additional variation to intolerances: eg., "side effects with 2 or more different classes of anti-hypertensives necessitating drug cessation, with suboptimal BP control on existing treatment"?

Commented [IW6R4]: Yes agree this sounds good

Commented [AF7]: Tricky one, what to do with this sort of at-risk patient?
Should they be referred anyway to assess end organ dysfunction, which means we try to convince patient to take treatment?? In truth, this sort of patient is also unlikely to attend a clinic anyway.
I'm not sure this needs to be stated as an absolute exclusion, it could be argued that a specialist clinic could try to persuade etc better than GP??

Commented [IW8R7]: Ok that is reasonable, I questioned this too but I thought I would add anyway and get thoughts. The access policy that I finally read at Austin re FTAs is actually interesting. It is fairly aggressive suggesting that we do not waste resources to ensure access to other patients (this is from the state gov too). So thought it worth a discussion.

Commented [WI10]: HTN statewide referral guideline but I have modified

	obstetric medicine will be accepted.				
Ambulatory Blood Pressure Monitor (ABPM)	• Patients who are suspected of hypertension and require an ABPM for diagnosis • Patients with hypertension on established therapy to assess hypertensive control • Patients suspected of nocturnal hypertension or autonomic dysfunction • Patients with comorbidities where adequate blood pressure control is an important primary or secondary prevention parameter as screening	• Meets Austin Health minimum referral information • If the clinician wishes for ongoing follow up through the hypertension clinic (noting that referral criteria for hypertension referrals must be met for ongoing follow up) • Blood pressure measurements, preferably taken on both arms on 2 occasions • Details of all relevant signs and symptoms • Relevant medical history and comorbidities • Any treatments previously tried, duration of trial and effect • Current and complete medication history (including non-prescription medicines, herbs and supplements and recreational or injectable drugs). • Correspondence or information from previous hypertension specialists if available	• History of smoking and alcohol intake • Liver function tests • Full blood examination results • Fasting lipid profile results • Estimated glomerular filtration rate (eGFR) • Urinalysis results • Fasting glucose and HbA1c% • Secondary screen if previously performed i.e. plasma or urine metanephrines, renin, aldosterone, renin-aldosterone ratio, 8am cortisol, thyroid function results • Urine protein test results • Renal artery duplex report (if renal artery stenosis is suspected and report is available) • Previous 12 lead electrocardiogram (ECG) tracings	**Urgent** if early onset hypertension or severe persistent hypertension **Semi-urgent** if uncontrolled hypertension with other comorbidities where hypertension control is an important primary or secondary prevention parameter Otherwise, **routine**	Patients will be seen by a hypertension clinician with the results of their ABPM. If a referral is made only for an ABPM, the patient will be discharged to the referrer for ongoing management, unless the control is clearly inadequate requiring timely intervention and follow-up by the clinic. Patients who do not meet the criteria for referral to the hypertension service will be discharged to the referring provider for ongoing management after initial consult with clinical exemptions at discretion of the clinical pharmacology department.

			• Echocardiogram report • If the person is pregnant or planning pregnancy • If the person identifies as an Aboriginal and Torres Strait Islander. • Height and weight		

Commented [WI11]: reused HTN statewide referral guideline but I have modified. Note that they do not have criteria for ABPM or hypotension