Hypotension Referral Guideline

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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:** • Acute onset hypotension of clinical concern • Hypotension with acute end organ dysfunction					
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: • **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**
Hypotension	• Patients with postural orthostatic tachycardia syndrome (POTS) or orthostatic intolerance (OI) who have not response to conservative management and/or basic medical therapy (e.g. fludrocortisone) if appropriate • functional impact of symptoms on daily activities including impact on work, study, or carer role • Exemptions may be made for certain clinical scenarios after discussion with clinical pharmacology **Referral not appropriate for:**	• Meets Austin Health minimum referral information • Observations: at minimum BP and HR on lying and standing on at least 1 occasion • Details of all relevant signs and symptoms • Relevant medical history and comorbidities • Any treatments previously tried, duration of trial and effect including non-pharmacological management (fluids, salt and compression stockings) • Current and complete medication history (including non-prescription medicines,	• Holter monitor • Echocardiogram • Beighton Score • 10 minute Stand Test • Tilt table test • Ambulatory Blood Pressure Monitor • 8am cortisol • Thyroid function tests • Full blood examination, urea, electrolytes and creatinine, liver function tests	**Urgent** if suspected or confirmed autonomic dysfunction **Semi-urgent** if symptoms have significant impact on daily function and have never been assessed by someone who has experience in managing POTS/OI All others will be triaged as **routine** unless exemption at discretion of the clinical pharmacology department	The Austin Hypotension/Blood pressure disorders clinic has an extended waitlist.

Commented [WI1]: This is from me

Commented [AF2R1]: "end organ dysfunction" probably should read "acute end organ dysfunction"?

Commented [WI3]: From palpitations state criteria

Commented [Ma4]: Agreed

	• Patients whose symptoms are not impacting function • Patients whose symptoms are stable under care of another medical specialist e.g. cardiologist or practitioner providing management of hypotension • Patients who are being referred for diagnosis of a connective tissue disease without symptoms of POTS or OI • Patients whose symptoms are of acute onset (< 3 months) or for whom another active medical diagnosis could explain their symptoms including an active eating disorder • Patient who have sporadic symptoms of short duration (<10 mins) • Patients who reside outside Victoria or Tasmania	herbs and supplements and recreational or injectable drugs) • Correspondence from previous specialists consulted for POTS and/or OI must be provided. • Correspondence from previous specialists consulted regarding a potential or actual diagnosis of a connective tissue disorder such as Ehlers-Danlos syndrome or hypermobility spectrum disorder. • ECG • Information regarding investigation of palpitations must be provided if relevant/available or include a comment on why investigations were not required.			
Autonomic Dysfunction	• High spinal cord injury (at or above T6) with suspected or confirmed autonomic dysfunction and symptoms of orthostatic intolerance (OI)/postural hypotension • Patients with isolated nocturnal hypotension and symptoms of OI and/or significant postural BP drop	• Meets Austin Health minimum referral information • Observations: at minimum BP and HR on lying and standing on at least 1 occasion • Details of all relevant signs and symptoms	• Holter monitor • Echocardiogram • 10 minute Stand Test • Tilt table test • Ambulatory Blood Pressure Monitor • 8am cortisol • Thyroid function tests	**Urgent**	The Austin Hypotension/Blood pressure disorders clinic has an extended waitlist.

Commented [Ma5]: I think you have covered it by what has been written above, but this is a nice example to illustrate that point – so leave it.

Commented [WI6]: From the palpitations guideline https://src.health.vic.gov.au/palpitations

	• Patients with suspected or confirmed autonomic dysfunction from another known or unknown cause with symptoms of OI • Exemptions may be made for certain clinical scenarios after discussion with clinical pharmacology **Referral not appropriate for:** • Patients whose symptoms are not impacting function • Patients whose symptoms are stable under care of another medical specialist e.g. cardiologist or practitioner providing management of OI • Patients whose symptoms are of acute onset (< 3 months) or for whom another active medical diagnosis could explain their symptoms • Patients who reside outside Victoria or Tasmania	• Relevant medical history and comorbidities • Any treatments previously tried, duration of trial and effect including non-pharmacological management (fluids, salt and compression stockings) • Current and complete medication history (including non-prescription medicines, herbs and supplements and recreational or injectable drugs) • Correspondence from previous specialists consulted for autonomic dysfunction or OI must be provided. • Correspondence from previous specialists consulted regarding a potential or actual diagnosis of a connective tissue disorder such as Ehlers-Danlos syndrome or hypermobility spectrum disorder. • ECG	• Full blood examination, urea, electrolytes and creatinine, liver function tests • HbA1c% and/or fasting glucose		