Women's Health Clinic Referral Guideline

Austin Health Women's Health Unit holds weekly clinics encompassing the diagnosis and management of problems due to oestrogen deficiency of androgen excess in women, both congenital and acquired causes.

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.
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.
Referral Process
GP Referral Guide: Please see below conditions accepted into this clinic and provide the relevant investigations as requested below to aid in the appropriate triaging of your patient.
Patient instructions: Please instruct your patient to bring **ALL** their diagnostic results to their Specialist Clinic appointment.
Exclusions: The Women's Health Unit does <u>not</u> provide the following services: • Fertility issues • Menopausal symptoms associated with natural/expected menopause (redirect to Mercy Hospital Menopause Clinic) • Pituitary adenomas (this condition is managed in the General Endocrinology Clinic) • Gender-affirming care (this condition is managed in the Transgender Clinic) • Delayed or arrested puberty (redirect to Paediatric Unit) • Patients with isolated gynaecological concerns

Condition / Symptom	**GP Management**	**Investigations Required Prior to Referral**	**Expected Triage Outcome**	**Expected Specialist Intervention Outcome**	**Expected number of Specialist Appointments**
Hypogonadism (including hypogonadotropic hypogonadism)	**When to Refer:** Amenorrhoea with persistently low oestrogen levels. **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, ovarian condition, pituitary condition, medical comorbidities and medications (e.g. chemotherapy), fertility plans **Imaging** Pituitary/pelvic imaging (as appropriate)	**Urgent:** Active plans for fertility. Symptomatic hypogonadism. Suspected pituitary pathology. **Routine:** All others	• Investigate cause and develop appropriate management plan depending on cause • Treatment with hormone replacement therapy (HRT)	5

Condition / Symptom	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome	Expected Specialist Intervention	Expected number of Specialist Appointments
Hypogonadism (continued)		**Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, progesterone, SHBG, testosterone, prolactin, TFTs, (other pituitary hormones if suspected hypopituitarism; cortisol, ACTH, IGF1, GH)		**Clinic exit criteria:** Women without confirmed hypogonadism or where not treatment is indicated. If clear treatment plan for ongoing HRT.	
Secondary amenorrhoea	**When to Refer:** 6+ months of unexplained amenorrhoea **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, progesterone, prolactin, TSH, BHCG	**Urgent:** Active plans for fertility. Suspected pituitary pathology. Cushingoid features. Masculinisation. Testosterone >5 nmol/L. **Routine:** This will be the majority	• Investigate cause and develop appropriate management plan depending on cause • Treatment with hormonal therapy (as appropriate) **Clinic exit criteria:** Return of normal menstruation. If clear treatment plan for ongoing therapy.	5
Turner syndrome	**When to Refer:** Turner syndrome with primary ovarian failure +/- osteoporosis +/- thyroid dysfunction **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Diagnostics** Chromosomal testing confirming Turner syndrome diagnosis	**Urgent:** Active plans for fertility. **Routine:** This will be the majority	• Treatment with appropriate therapy **Clinic exit criteria:** If clear treatment plan for ongoing therapy.	No specific limit

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Gonadal dysgenesis	**When to Refer:** Symptomatic hypogonadism, osteoporosis. **Previous treatment already tried:** Hormone replacement therapy	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, progesterone, BHCG	**Urgent:** Active plans for fertility. Symptomatic hypogonadism.	• Treatment with hormonal therapy (as appropriate) **Clinic exit criteria:** If clear treatment plan established	No specific limit
Premature menopause and premature ovarian insufficiency	**When to Refer:** Menopause or menopausal symptoms before age 45. **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, progesterone, BHCG, prolactin, TSH	**Urgent:** Active plans for fertility. Severe menopausal symptoms. **Routine:** All others	• Investigate cause and develop appropriate management plan depending on cause • Treatment with hormonal therapy (as appropriate) **Clinic exit criteria:** Stable on therapy with a clear treatment plan.	5
Congenital adrenal hyperplasia (CAH)	**When to Refer:** Suspected diagnosis of CAH or for confirmation of type. For initiation of treatment.	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Diagnostics** (0800 hours) 17 (OH) progesterone, UEC	**Urgent:** Suspected new diagnosis. Active plans for fertility. **Routine:** All others	• Confirmation of diagnosis • Treatment with appropriate therapy **Clinic exit criteria:** Stable on therapy with a clear treatment plan.	No specific limit

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Hirsutism	**When to Refer:** new or progressive hirsutism **Previous treatment already tried:** Hair removal treatments	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, SHBG, DHEAS, testosterone, glucose, lipids, TSH	**Urgent:** Cushingoid features. Masculinisation. Testosterone >5 nmol/L. **Routine:** Hirsutism without severe androgen excess. This will be the majority	• Investigate cause and develop appropriate management plan depending on cause **Clinic exit criteria:** Issue resolves. Stable on therapy with a clear treatment plan.	2
Oligomenorrhoea (irregular periods)	**When to Refer:** N/A **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, progesterone, prolactin, TSH, BHCG	**Urgent:** Active plans for fertility. Suspected pituitary pathology. Cushingoid features. Masculinisation. Testosterone >5 nmol/L. **Routine:** This will be the majority	• Investigate cause and develop appropriate management plan depending on cause **Clinic exit criteria:** Issue resolves. Stable on therapy with a clear treatment plan.	3
Premenstrual syndrome	**When to Refer:** Severe physical and emotional symptoms 1-2 weeks before menstruation **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Diagnostics** N/A	**Urgent:** N/A **Routine:** This will be the majority	• Develop appropriate management plan **Clinic exit criteria:** Issue resolves. Stable on therapy with a clear treatment plan.	3

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Polycystic ovarian syndrome (PCOS)	**When to Refer:** For diagnostic clarification of suspected PCOS. Persistent PCOS symptoms despite treatment. **Previous treatment already tried:** N/A	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** (0800-0900 hours, fasted) LH, FSH, oestradiol, TSH, BHCG, DHEAS, testosterone, glucose, lipids, 17 (OH) progesterone	**Urgent:** Active plans for fertility **Routine:** This will be the majority	• Assessment of PCOS diagnosis • Initiation of treatment for symptoms **Clinic exit criteria:** Stable on therapy with a clear treatment plan.	3
Gynaecological problems (gynaecology clinic runs concurrently every 4 weeks with endocrinology clinic) Referrals for gynaecological issues will only be accepted if the patient **<u>also</u>** meets criteria for another endocrinology-related condition listed above in this guideline.	**When to Refer:** Irregular PV bleeding. Sexual health concerns. Pelvic pain in women. **Previous treatment already tried:** Analgesia *Patients with isolated gynaecological concerns should be referred directly to a dedicated gynaecology service.*	**To be included in referral** Age, BMI, reproductive history, medical comorbidities and medications, fertility plans **Imaging** Pelvic US (TVUS preferred) **Diagnostics** BHCG, pap smear	**Urgent:** Active plans for fertility. New PV bleeding post-menopause. Severe pelvic pain not amenable to analgesia. **Routine:** All others	• Investigate cause and develop appropriate management plan depending on cause **Clinic exit criteria:** Issue resolves. Stable on therapy with a clear treatment plan.	3