Derbyshire Healthcare NHS Foundation Trust

Derby Teaching Hospitals NHS Foundation Trust

Southern Derbyshire Clinical Commissioning Group

Derby and Southern Derbyshire

REFERRAL GUIDELINES FOR PAEDIATRIC OUT–PATIENTS FROM PRIMARY CARE

Version 1
December 2017

Paediatric Clinical Improvement Group (CIG)

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These guidelines have been developed by the Derby Paediatric Clinical Improvement Group, including paediatricians (General and Community), paediatric subspecialists, and GP Children's leads in Derbyshire, to give advice on appropriateness of referrals, pre-referral requirements and alternative pathways for the most common paediatric conditions. They are of relevance when considering referrals to both general and community paediatrician services.

The intention is to keep the guidelines relevant and up- to date and we anticipate that they will evolve, and be added to. They will be formally reviewed at least annually by a working group. In between reviews we would be grateful if users could point out any inaccuracies or changes in details. We would also welcome suggestions for additions to the guidelines. Please contact the Paediatric team at Derbyshire Children's Hospital 01332 340131 ext. 86830 or email trish.fletcher@nhs.net .

The guidelines are a general guide as to what is felt appropriate for referral to specialist paediatric services. However they do not necessarily mean that all children who meet the criteria MUST be referred as in many cases there will be some GPs who have the skills and expertise to manage the condition in primary care. If children are already known to any paediatrician - even for a new or different problem - please consider contacting them first before making a new referral to another paediatrician.

This document is not designed to be a guide to acute/urgent management of unwell children. Advice for such conditions can be accessed via NICE guidance, or by contacting the GP line in Children's Emergency Department (CED) on **01332 785572**.

Throughout the document we have used symbols below to indicate the appropriate mode of referral depending on urgency;

☎same day telephone contact advised

✉ routine outpatient referral

💻 email referrals

(Thanks to Nottinghamshire, on whose guidelines these are based).

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Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
ALLERGY	COW'S MILK PROTEIN ALLERGY	Follow local guidance and ensure discussion with health visitor. Direct referral to dietitian pathway - LINK Only refer to paediatrics if red flags. Follow JAPC Infant Feeding Guidelines CKS – NICE Colic - infantile Ensure parental support for coping with crying and safety netting including informing Public Health Nurse (health visitor)	☎ Acute severe concerns despite cow's milk exclusion trial ✉ Faltering growth despite a cow's milk exclusion trial ✉ Direct to dietitian as per pathway ✉ History of IgE mediated reaction to dairy i.e. urticaria, angioedema, immediate vomiting or diarrhoea or any rash with rapid onset ✉ Concern re multiple allergies	General Paediatrics Paediatric dietitian Suspected IgE mediated cow's milk allergy – Paediatric Allergy Clinic
	ALLERGIC RHINITIS	Please follow shared care guideline for management and referral of severe allergic rhinitis.	✉ Severe allergic rhinitis not responding to maximal medical treatment	Paediatric Allergy Clinic

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	DRUG ALLERGY	Please see NICE guidance on drug allergy: https://www.nice.org.uk/guidance/cg183 .	✉ a suspected drug related anaphylactic reaction / a severe non-immediate cutaneous reaction (for example, Stevens–Johnson Syndrome). ✉ Anaesthetic drug reaction ✉ multiple antibiotic allergies / beta lactam allergies in immunocompromised children	Paediatric Allergy Clinic
	EGG ALLERGY	Many cases of Egg Allergy can be managed in primary care. Please see local guideline.	✉ suspected anaphylaxis ✉ children with co-existing asthma on regular preventative inhalers ✉ multiple food allergies ✉ where diagnosis unclear ✉ when egg allergy persists beyond age 6-8 years	Paediatric Allergy Clinic
	OTHER SUSPECTED ALLERGY	Follow NICE Allergy Guidance for advice regarding referral and assessment. Please see shared care paediatric allergy guideline for further advice on referral. Advise avoidance of potential allergen. Simple single (IgE mediated) food allergies with only cutaneous symptoms and no anaphylaxis symptoms or respiratory involvement may be managed with avoidance advice and written management plan (this excludes nuts and	✉ Clinical/ parental suspicion of multiple IgE mediated reactions/ cross-reactions ✉ Strong clinical suspicion of IgE mediated food allergy ✉ IgE reactions to foods with a high risk of anaphylaxis e.g. egg, tree nuts, peanuts, shellfish, kiwi, sesame ✉ Suspicion of IgE mediated food allergy and concurrent asthma	IgE mediated – Paediatric Allergy Clinic

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		seeds). Acute isolated urticarial rashes with no suspected trigger may be managed symptomatically with antihistamines and do not need allergy clinic referral. Chronic urticaria (>6 weeks) is unlikely to be due to allergy but Paediatric Allergy clinic may be appropriate if high parental concern. Consider referral to paediatric dermatology or paediatric allergy if uncontrolled by regular high dose antihistamines. Severe eczema refractory to treatment when suspected food cause – please refer to dermatology initially for eczema management.		
BEHAVIOURAL /EMOTIONAL AND WELLBEING CONCERNS CKS – NICE Autism in Children CKS –NICE Conduct disorders in children and	CONCERNING BEHAVIOUR	Gather information about concerns from other services involved e.g. nursery, school, social care/MAT. Consider Early Help Assessment: Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council		Refer to SPOA only if concerns regarding neurodevelopment or mental health concerns.

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young people CKS – NICE Depression in children CKS – NICE Eating Disorders		Refer to local offer websites for other support mechanisms ✓ Derbyshire Local Offer ✓ Derby City Local Offer Refer to public health nursing team for further advice on local services for • Toddler tantrums • Conduct disorder • Anger management		
	POSSIBLE NEURO-DEVELOPMENTAL CONCERN (ADHD / AUTISTIC SPECTRUM DISORDER)	Gather information about concerns from other services involved e.g. nursery, school, social care/MAT. Request "current concerns" form from educational setting (encourage school teachers and school health to make the referral directly to Single point of access). Consider Early Help Assessment to engage MAT (details above) See "**SPOA referral form**" and ND info leaflets/questionnaires on CCG website. **Patient Information Leaflet** Hyperactive behaviour information		Refer to Single Point of Access (SPOA) using form.
	ANXIETY /OCD/PHOBIAS	Assess for other symptoms associated with medical causes of anxiety disorders	☎ if significant self-neglect from anxiety/OCD	CAMHS RISE team - 0300 123 3124

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		(e.g. hyperthyroidism) and consider checking FBC, UE, LFT, TFTs. Gather information about concerns from other services involved e.g. school If under 16 or in school, refer to school health for assessment Consider SafeSpeak referral (RELATE) or similar. If over 16, consider self-referral to IAPT providers (e.g. Trent PTS, Talking Mental Health Derbyshire) if no significant current self-harm. **Patient Information Leaflet** Anxiety information for Young People Anxiety information for parents Coping with stress	✉ If moderate or severe symptoms or considering need for psychotropic medication	Refer to CAMHS.
	LOW MOOD / DEPRESSION	Assess for other symptoms associated with medical causes of low mood (e.g. hypothyroidism) Gather information about concerns from other services involved e.g. school If low risk / mild symptoms If under 16 or in school, consider referral to school health for assessment	☎ if severe self-neglect, or significant concerns regarding suicidal ideation ✉ If moderate or severe symptoms or considering need for psychotropic medication	CAMHS RISE team - 0300 123 3124 CAMHS referral

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		Consider SafeSpeak referral (RELATE) or similar. If over 16, consider self-referral to IAPT providers (e.g. Trent PTS, Talking Mental Health Derbyshire) if no significant current self-harm. **DON'T** start antidepressants (see NICE guideline link)		
	SELF-HARM / SUICIDAL THOUGHTS	Assess for other comorbidities (e.g. depression, social and safeguarding issues) Gather information about concerns from other services involved e.g. school If low risk / mild symptoms If under 16 or in school, consider referral to school health for assessment If over 16, consider self-referral to IAPT providers (e.g. Trent PTS, Talking Mental Health Derbyshire) if no significant current self-harm.	☎ Acute self-harm requiring physical medical treatment ☎ Acutely at risk of self-harm	Admit to hospital (CED). CAMHS RISE team - 0300 123 3124
	EATING DISORDER (anorexia nervosa /	Unusual diets not classed as an eating disorder monitor weight and support	☎ Amber or Red Physical Risk Factor ✉ Concern about underlying medical	General

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	bulimia nervosa)	from universal services Assess for medical causes of weight loss (e.g. IBD, coeliac, thyroid) Plot growth including BMI on growth chart (see UK90 chart) and assess speed of weight loss Carry out risk assessment See CKS – NICE Eating Disorders or Junior MARSIPAN Guidance for GPs (Page 34) to perform assessment of risk including ECG, Lying and standing BP, Pulse, FBC, U&E, LFT, TFT, Ca, Mg, PO4 **Patient Information Leaflet** Eating Disorders Parent and Young Person information leaflet	condition – (☎concerns re brain tumour) If less than 70% weight for height then refer for urgent paediatric assessment or pulse less than 40 If 70-80% weight for height then refer for an urgent CAMHS Eating Disorder assessment. If no concerns regarding low weight / weight loss but concerns that eating or thoughts around eating are becoming disordered consider referral to First Steps. Parents/children and young people can self-refer to First Steps and CAMHS Eating Disorder team	Paediatrics ☎ CAMHS Eating Disorders service Mon – Fri 9am – 5pm 0300 790 0264 Consider referring to First Steps at the same time as referral to CAMHS
	SCHOOL REFUSAL	Gather information about concerns from other services involved e.g. nursery, school, CAMHS Consider Early Help Assessment ✓ Derbyshire County Council ✓ Derby City Council	✉ **Only if** underlying medical condition impacting on ability to attend school which may warrant referral in own right	Single point of access (SPOA) – form here
CARDIAC	MURMURS	If murmur first noticed in the context of an acute illness in an otherwise thriving child review once well and refer if	☎ Oxygen saturation <92% ☎ Absent or weak femoral pulse ☎ Evidence of heart failure (respiratory	General Paediatrics

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		persists. Plot growth on growth chart see UK90 chart Transient or clearly innocent murmurs do not need to be referred. Persistent murmurs may be referred for routine paediatric review	distress, hepatomegaly, oedema etc.) ✉ Faltering growth	
	HISTORY SUGGESTIVE OF ARRHYTHMIA / PALPITATIONS			General Paediatrics
	FAMILY HISTORY OF CARDIOMYOPATHY IN 1ST DEGREE RELATIVE			General Paediatrics
	UNEXPLAINED COLLAPSE	ECG to rule out prolonged QTc or other arrhythmia, if possible. Vasovagal symptoms in young people should prompt checking a lying and standing BP / Pulse. If there is a significant postural drop in BP (>20mmHg) or raise in pulse (30bpm) advise increasing fluid and salt intake and refer if no clinical improvement after 6 –	Consider referral for recurrent episodes.	General Paediatrics

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		8 weeks. **Patient Information Leaflet** Syncope and fainting		
	HYPERTENSION > 95th centile for age and height	Check BP manually if possible.		General Paediatrics
DERMATOLOGY	ACNE	Please see guidance CKS- NICE Acne Guideline	✉ Not responding to topical appropriate systemic treatment ✉ Scarring	Paediatric Dermatology
	BIRTHMARKS - INFANTILE HAEMANGIOMA OR OTHER (VASCULAR, PIGMENTED, EPIDERMAL, UNKNOWN)	Action depends on type of birthmark and age :- To clarify uncertain diagnosis – refer paediatric dermatology Strawberry birthmarks/Infantile haemangioma refer to paediatric dermatology ✉ Port wine stains refer to QMC Nottingham for laser treatment. ✉ In older children requesting excision of birthmark refer to plastic surgeons	Infantile haemangioma: ☎ Interfering with eating ☎ Ulcerated / Infected ☎ Beard area / Concerns about airway ✉ Interfering with function e.g. vision, hearing ✉ Associated with other problems ✉ Midline ✉ At risk of poor cosmetic outcome ✉ Port wine stain on the face Refer if Diagnosis uncertain	Paediatric Dermatology Plastic Surgeons (QMC)

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		Please refer first to PLCV procedures of limited clinical value guidance		
	ECZEMA	Please refer to CKS - NICE Atopic Eczema Guideline Please also see local JAPC emollient guidance. **Patient Information Leaflets** Eczema Treatment Factors Home Environment	☎ Suspected Eczema Herpeticum (rapidly worsening, fever, blisters, punched out erosions) ☎ Infected and not responding to treatment ✉ Severe and not responding to optimum topical therapy after 1 week ✉ Uncertain diagnosis ✉ Management as per NICE guidance not controlling (lower threshold if on the face) ✉ Causing significant social or psychological problems ✉ Associated with severe and recurrent infections especially deep abscesses or pneumonia ✉ Specialist parental support with application treatment required	Paediatric Dermatology
	GENITAL (VULVAL OR PENILE) DERMATOSES	See Genitourinary below		
	SUSPECTED TINEA CAPITIS	See CKS –NICE Fungal Infections of the scalp Consider taking samples for mycology	☎ Severe Kerion with hair loss ✉ If not responding to treatment	Paediatric Dermatology

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		and start systemic treatment **Patient Information Leaflet** Fungal infections of the scalp		
	ALOPECIA AREATA OR DIFFUSE HAIR LOSS	Check ferritin and give iron replacement if less than 40 mg/ml Please see CKS - NICE Alopecia Areata British Association of Dermatologists Guidelines **Patient Information Leaflet** Alopecia Areata	✉ No hair regrowth and more than 50% hair loss ✉ Considering treatment	Paediatric Dermatology
	NAIL DYSTROPHY	Fungal nail infection is uncommon in children, and the oral treatments are not licensed for this age group Take samples for mycology Please see CKS - NICE Fungal Nail Infection	✉ Oral antifungal treatment is required ✉ Diagnosis is uncertain ✉ Topical unsuccessful ✉ Immunocompromised	Paediatric Dermatology
	HYPERHIDROSIS	Please see CKS - NICE Hyperhidrosis Consider referral to adult dermatology for consideration of Botox in over 16s	✉ Not responding to lifestyle measures or 20% aluminium chloride hexahydrate	Paediatric Dermatology

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		with axillary hyperhidrosis.		
	MOUTH ULCERS		✉ Severe or recurrent ✉ Associated with genital ulcers ✉ Associated with gut symptoms	Paediatric Dermatology **If genital or gut symptoms:** General Paediatrics
	GUTTATE OR PLAQUE PSORIASIS	CKS - NICE psoriasis Commence topical treatment	✉ if unresponsive to treatment	Paediatric Dermatology
	MOLLUSCUM CONTAGIOSUM	Please see CKS - NICE Molluscum contagiosum Eyelid margin or ocular lesions and associated red eye ☎Paediatric Ophthalmologist Consider differential diagnosis genital warts see genitourinary section below	✉ Periocular ✉ Immunocompromised	Paediatric Dermatology
	SCABIES – PERSISTENT	Please see CKS - NICE Guidance Scabies ☎ Refer institutionalised outbreaks of scabies (e.g. schools or nurseries,	☎ Crusted scabies as admission may be required ☎ Scabies is rare in children under 2 months of age. Seek specialist advice (e.g.	

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		residential settings) to the Health Protection Agency	from a paediatric dermatologist) if treatment is required for this age group ✉ Diagnostic uncertainty ✉ Treatment failure (e.g. if two courses of an insecticide have failed).	Paediatric Dermatology
	VIRAL WARTS	Please see CKS - NICE Guidance warts and verrucae (Anogenital warts - see genitourinary below).	✉ Hands and Feet, only if significantly interfering with function e.g. Writing or walking ✉ Face, only if causing significant distress ✉ Persistent, causing distress and unresponsive to topical salicylic acid ✉ Diagnostic uncertainty ✉ Immunocompromised	Paediatric Dermatology
	SUSPECTED MELANOMA	Please see CKS - NICE melanoma and pigmented lesions	Refer via **2 week wait** paediatric dermatology or discuss with on call dermatologist ☎	Not appropriate for routine Outpatient referral
	CONGENITAL SKIN MALFORMATION	Please refer first to PLCV guidance Consider paediatric plastics or ENT if eligibility for excision confirmed		
	SKIN LESION OR RASH FOR DIAGNOSIS	Persistent unexplained skin lesions/rashes that have not responded to treatment should be referred for		Paediatric Dermatology

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		diagnosis. If deep/bony consider orthopaedic referral.		
	HYPERTROPHIC OR KELOID SCAR	Please refer first to PLCV guidance	✉ Symptomatic or continuing to grow	Paediatric Dermatology
	URTICARIA	Also see Allergy section Start treatment with up to double the dose non-sedating antihistamine Please see CKS - NICE guidance Urticaria	✉ Chronic i.e. lasting more than 6 weeks on a daily basis, not controlled by antihistamines ✉ Associated with angio-oedema	Paediatric Dermatology Paediatric Allergy Clinic
	VITILIGO	Please see CKS - NICE guidance vitiligo		Paediatric Dermatology
DEVELOPMENT	GENERALISED DELAY IN DEVELOPMENT OR LEARNING DISABILITY IN OLDER CHILD	Gather information about concerns from other services involved e.g. nursery, school, CAMHS For school age children, SENCO and educational psychologist first line - only refer via SPOA if never seen previously by paediatrician. Consider Early Help Assessment / Starting Point referral for early help and parenting support	✉ Developmental regression or concern re severe complex neurodisability should be seen urgently	Community Paediatrics

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		✓ Derbyshire County Council ✓ Derby City Council		
	SPEECH AND LANGUAGE DELAY ONLY	Gather information about concerns from other services involved e.g. nursery, school, CAMHS Arrange hearing test if not done Consider Early Help Assessment Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council		Not appropriate for paediatric outpatients Refer to DCHS Speech and Language (see local criteria)
	MOTOR DELAY		✉ Focal neurological signs or asymmetry.	Community Paediatrics
	DEVELOPMENTAL COORDINATION DIFFICULTIES (DYSPRAXIA)	Physical literacy via school. **Patient Information Leaflet** DCD information leaflet	Refer to Community Physiotherapy/ Occupational therapy (this can be done by school if physical literacy done)	
	SPECIFIC EDUCATIONAL DIFFICULTIES E.G. DYSLEXIA	Discuss with Special Educational Needs Coordinator (SENCO) at school		Not appropriate

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DYSMORPHIC FEATURES				Community Paediatrics
EAR NOSE AND THROAT		See PCLV referral forms for grommets, tonsillectomy guidelines etc prior to any referral. See NICE Guidance CKS – Otitis media – acute CKS – Otitis media Chronic suppurative CKS – Otitis media with effusion (Please see Respiratory -> Sleep disordered Breathing (Snoring with periods of apnoea) for indications for paediatric input)		Paediatric ENT
ENDOCRINOLOGY	THYROID DYSFUNCTION		☎ If child unwell or considering starting treatment ✉ all children with thyroid disorder	General Paediatrics
	SUSPECTED DIABETES	If diabetes is suspected then must be referred the same day to CED even if relatively well as children can decompensate rapidly.	☎ Hyperglycaemia (random plasma glucose/BM more than 11 mmol/litre)	Routine referral is not appropriate - should be seen same day in CED

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GASTRO-INTESTINAL	CONSTIPATION AND SOILING	Refer to CKS - NICE Constipation guidance for further information and local paediatric constipation guideline. Plot growth on growth chart see UK90 chart **Patient Information** ERIC – The Children's Bowel and Bladder Charity website Blood separate to the stool is usually associated with constipation and anal fissure and should be treated as above.	☎ Abdominal distension with vomiting ☎ Failure to pass meconium first 48 hrs ✉ Reported from birth or first few weeks of life ✉ Previously unknown or undiagnosed weakness in legs, motor delay ✉ Faltering growth ✉ No response to initial management as per NICE guidance within 4-6 weeks	General Paediatrics
	PERSISTENT DIARRHOEA	Plot growth on growth chart see UK90 chart See CKS – NICE Gastroenteritis Post gastroenteritis lactose intolerance can be treated with 2-week trial of lactose free formula. Follow JAPC Infant Feeding Guidelines. Lactose intolerance parent leaflet Toddler diarrhoea parent leaflet	☎ Blood in stool ☎ Weight loss ☎ Associated significant vomiting ☎ Bloody diarrhoea ✉ Persists over 2 months ✉ Faecal calprotectin greater than 200 micrograms /g	General Paediatrics

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	CHRONIC OR RECURRENT ABDOMINAL PAIN	History and through examination to exclude red flags. Do not routinely perform blood tests / USS If school absence gather information about concerns from other services involved e.g. nursery, school, CAMHS Consider Early Help Assessment Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council Plot growth on growth chart see UK90 chart	☎ Gastrointestinal blood loss ☎ Significant vomiting ☎ Unexplained fever ✉ Weight Loss ✉ Deceleration in linear growth ✉ Persistent pain not periumbilical ✉ Family History Inflammatory Bowel disease ✉ Significant school absence	General Paediatrics
	GASTRO-OESOPHAGEAL REFLUX	Use JAPC guideline. Refer to CKS - NICE Gastro oesophageal reflux for further information **Parent Information Leaflet** Gastro oesophageal reflux parent leaflet Plot growth on growth chart see UK90 chart	✉ No response to initial management as per NICE guidance within 4-6 weeks **Infants** ☎ Frequent forceful vomiting -consider pyloric stenosis ☎ Bile stained ☎ Haematemesis unless obvious cause e.g. cracked nipple and breast fed ☎ Blood in stool ☎ Abdominal tenderness or mass ☎ Vomiting associated with rapidly increasing head circumference ✉ Late onset vomiting >6mths	General Paediatrics

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			✉ Associated atopy ✉ Faltering growth **Children & YP** ☎ Above or early morning vomiting and headache ✉ Significant symptoms > 1yr old ✉ Consider as a cause of unexplained distress in children with neurodevelopmental disorders	
	NEONATAL JAUNDICE	See CKS - NICE Jaundice in the newborn	☎ As per CKS - NICE Jaundice in the newborn Prolonged jaundice over 2 weeks	☎ Midwives to arrange bilirubin ☎ Prolonged refer direct to DTHFT daycase (01332 786856).
	JAUNDICE (OUTSIDE NEONATAL PERIOD)	See CKS - NICE Gilbert's Syndrome	☎ Not typical of Gilbert's syndrome	CED direct line (01332 785572)
GENERAL HEALTH	GENERAL MALAISE / FATIGUE	Ensure good sleep hygiene see Sleep Council Consider NICE Guidance Chronic Fatigue Syndrome CKS – NICE Depression in children Perform "tired all the time" bloods (use	✉ Impacting significantly on daily function	General Paediatrics Over 16 use Adult CFS pathway

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		the specific panel on ICE system). Offer to see young people on their own and perform brief psychosocial assessment. Gather information about concerns from other services involved e.g. school, CAMHS Consider Early Help Assessment for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council **Parent Information** Sleep Council Sleep tips for teenagers		
GENITOURINARY	RECURRENT URINARY TRACT INFECTION	See CKS - NICE UTI children Always send urine if considering treatment Treat constipation and dysfunctional elimination syndromes, encourage adequate oral intake and ask about access to clean toilets at school to avoid voiding delay	☎ < 3 months ☎ Atypical UTI • seriously ill • poor urine flow • abdominal or bladder mass • failure to respond to treatment with suitable antibiotics within 48 hours • non-E. coli infection (NICE 2016 recommends USS during the acute infection to identify structural abnormalities of the urinary	General Paediatrics

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			tract such as obstruction to ensure prompt management) ✉ Well but aged 3 – 6 months ✉ Recurrent UTI includes • 2 or more episodes of UTI with acute pyelonephritis/upper urinary tract infection • 1 episode of UTI with acute pyelonephritis/upper urinary tract infection plus 1 or more episode of UTI with cystitis/lower urinary tract infection • 3 or more episodes of UTI with cystitis/lower urinary tract infection	
	ENURESIS – NOCTURNAL	See CKS - NICE Enuresis First line referral to Public Health Nursing Team (school nursing). Gather information about concerns from other services involved e.g. nursery, school, CAMHS Consider Early Help Assessment Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council **Patient Information** ERIC – The Children's Bowel and Bladder	✉ No response to intervention from nursing team ✉ Lack of response to treatment with an alarm and/or desmopressin ✉ Secondary Enuresis (previously dry for >6mths). NB: please consider possibility of underlying medical problem e.g. diabetes first.	General Paediatrics

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		Charity website		
	ENURESIS – DIURNAL	Gather information about concerns from other services involved e.g. nursery, school, CAMHS Consider Early Help Assessment / Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council **Patient Information** ERIC – The Children's Bowel and Bladder Charity website	✉ Child >3 years where the child's general development is not delayed, toilet training has been attempted	General Paediatrics
	VULVAL PROBLEMS INCLUDING VULVOVAGINITIS	Give parents advice about appropriate hygiene. Do not routinely swab. Consider and treat UTI, threadworms CKS - NICE Threadworm, constipation. (Note: Candida is rare in young children once out of nappies unless immunodeficient - do not prescribe treatment routinely). Use Vaseline as barrier. **Patient Information** Vulvovaginitis Leaflet Labial Adhesions Leaflet Vulval Appearance Leaflet	✉ Shiny, smooth red skin (?lichen sclerosis) ✉ Recurrent despite appropriate hygiene advice and management of UTI, threadworms, candida ✉ Labial adhesions Consider risk factors for Child Sexual Abuse only if disclosure or clear concerns including social concerns, signs of perineal/perianal trauma with no appropriate accidental or constipation history or vaginal bleeding in pre-pubertal child. See section on Safeguarding/Child Protection.	Paediatric Dermatology General Paediatrics

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			NB: vulvovaginitis alone without other risk factors, disclosure or clinical signs is rarely an indicator of sexual abuse.	
	RECURRENT BALANITIS / NON-RETRACTILE FORESKIN > 5 YEARS	For tight apparently non-retractile foreskin in older boys give advice re hygiene and gentle retraction and consider short course of topical steroids prior to referral. NHS Choices – tight foreskin		Paediatric Surgery
	VULVAL OR PENILE RASH FOR DIAGNOSIS AND MANAGEMENT			Paediatric Dermatology
	PERSISTENT NAPPY RASH	Please refer to CKS -NICE nappy rash Consider safeguarding.	✉ Uncertainty about the diagnosis ✉ Nappy rash remains distressing despite treatment. ✉ Nappy rash is recurrent and distressing, requiring repeated treatment (e.g. topical corticosteroids)	Paediatric Dermatology
	GENITAL WARTS	Consider indicators of sexual abuse. First presentation of genital warts is an indicator of sexual abuse - see safeguarding/child protection section.	☎ Refer to children's social care for strategy discussion	Protocol under development

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
		Sexually active older children - website for sexual health options ✉ Sexual Health Services		Genito-Urinary Medicine
	UNDESCENDED TESTES -BILATERALLY OR UNILATERAL	See CKS –NICE Undescended testes	☎ Neonates – if both are undescended this may be sign of endocrine abnormality or disorder of sexual development discuss immediately with Paediatrician. ✉ if persisting beyond age 3 months	Paediatric Surgeons
	HYPOSPADIAS	Ensure child is not circumcised.		Paediatric Surgeons
	MENSTRUAL PROBLEMS	*If secondary amenorrhoea check urgent βHCG is negative before referring **Patient Information** Polycystic Ovary Syndrome Vulval Appearance Leaflet	✉ Menorrhagia or severe dysmenorrhoea ✉ Primary or secondary amenorrhea* ✉ Signs or symptoms of PCOS ✉ Concerns re anatomy that cannot be reassured	General Paediatrics
	SEXUAL HEALTH / CONTRACEPTION	✉ Sexual Health Services		Not appropriate Sexual Health Services
GROWTH	CONCERNS ABOUT	Unless acute weight loss / failure to thrive, plot growth over 3-6 months and	✉ Height <0.4th centile or decreased by more than two centile bands	General Paediatrics

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	SHORT STATURE	calculate mid-parental height; see UK90 chart. How to calculate mid parental height	✉ Height outside expected for mid-parental height ✉ Associated failure to thrive / weight loss	
	TALL STATURE / EXCESSIVE GROWTH	Plot growth over 3-6 months and calculate mid-parental height; see UK90 chart. How to calculate mid parental height	✉ Height >99.6th centile or increased by more than two centile bands ✉ Height outside expected for mid-parental height ✉ Family history (e.g. Marfan's)	General Paediatrics
	OBESITY	Refer to LiveWell if in Derby. There is currently no obesity service in Derbyshire. Plot growth including BMI on UK90 chart Use Public Health (school) Nurses. **Parent/child information** Change4 Life NHS Choices	✉ Acanthosis Nigricans ✉ Cushing's syndrome or Polycystic Ovarian Syndrome (PCOS) ✉ Signs of genetic obesity syndrome (very rare - present with very early extreme onset obesity) ✉Signs of Hypothyroidism ✉Hypertension	General Paediatrics
	FALTERING GROWTH	Plot growth on growth chart - see UK90 chart. Gather information about concerns from other services involved e.g. nursery,	✉ Weight <0.4th centile or drop of more than 2 centiles	General Paediatrics

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		school, CAMHS. Consider Early Help Assessment / Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council		
HAEMATOLOGY / ONCOLOGY	SUSPECTED MALIGNANCY	If persistent lymphadenopathy see below under infection.	Refer via **2 week wait** or discuss with on call paediatrician ☎	Not appropriate for routine Outpatient referral
	ABNORMAL BLEEDING / MULTIPLE BRUISING THOUGHT TO BE DUE TO A BLEEDING OR CLOTTING ABNORMALITY	Please see CKS – NICE Bruising If unexplained bruising thought to be Non-Accidental Injury then see safeguarding/child protection section	☎ If acute medical bruising / bleeding, discuss with paediatrics on call for medical investigation and management ✉ Abnormal bleeding or bruising with no evidence of malignancy or safeguarding concerns warrants further investigation.	General Paediatrics
	HAEMOGLOBIN-OPATHY	Most children are diagnosed via the neonatal screening programme. Arrange haemoglobinopathy screen before referral for those who may have missed neonatal screening. Carriers generally do not need referral.	☎ known haemoglobinopathy or family history and acutely bleeding/ swollen joint	

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
HEAD SIZE / SHAPE CONCERNS	SLOW HEAD GROWTH	Plot growth on growth chart; see UK90 chart. Measure parents head circumference in absence of other concerns may be able to diagnose as familial.	✉ Associated dysmorphic features or concerns about development	Community Paediatrics (only if co-existing developmental delay or dysmorphic features)
	EXCESSIVE HEAD GROWTH – OFC INCREASING	Plot growth on growth chart; see UK90 chart. Measure parents head circumference in absence of other concerns may be able to diagnose as familial.	☎ Signs or symptoms of raised ICP ✉ Crossing 2 centiles ✉ Associated dysmorphic features/ skeletal dysplasia	CED General paediatrics
	ABNORMAL HEAD SHAPE	Plot growth on growth chart; see UK90 chart. **Patient Information** Plagiocephaly NHS Head Turning Preference and Plagiocephaly	☎ Signs or symptoms of raised ICP ✉ Ridged sutures at 6-week check ✉ Absent anterior fontanelle prior to 6 weeks (may be 1 – 4.7cm) ✉ Significant parental distress despite reassurance and leaflet	CED General paediatrics
INFECTIONS	RECURRENT OR PERSISTENT/ ATYPICAL INFECTION	For more information please see Clinical Immunology Review Series: An approach to the patient with recurrent infections in childhood	✉ >8 new infections within 12 months ✉ >2 serious sinus infections or episodes of pneumonia in 1 year ✉ Failure of an infant to gain weight or grow normally	General Paediatrics

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
			✉ Recurrent deep skin abscesses ✉ Persistent superficial candidiasis after age 1 year ✉ Episode of opportunistic infection ✉ Complication associated with live vaccination ✉ >2 invasive infections ✉ A family history of primary immune deficiency ✉ Unexplained autoimmune disease	
	PERSISTENT LYMPHADENOPATHY	Please see also Lymphadenopathy in children: refer or reassure? Prolonged duration of lymph nodes which are small and non-progressive do not usually need referral.	☎ >2cm and persisting > one month and increasing in size ☎ Hepatomegaly / splenomegaly ☎ Pallor ☎ Weight loss ☎ Unexplained fever ☎ Other significant lymphadenopathy	Not usually appropriate for routine outpatient referral - please phone CED for rapid access clinic appt. if required.
	RECURRENT FEVERS	Consider possible recurrent UTI, autoimmune disease, and also see 'Recurrent/ atypical Infection' guidance.		General Paediatrics
MUSCULO-SKELETAL	GROWING PAINS / CHRONIC JOINT PAIN	Check Vitamin D level. Perform Paediatric Gait Arms Legs Spine Assessment Useful Summary:	☎ Systemic upset e.g. fever, malaise, anorexia, weight loss, bone pain, worsening night pain ✉ Occurs at start of day after waking ✉ Limp ✉ Asymmetrical ✉ Physical Activities significantly limited	General Paediatrics

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
		'Growing Pains' A Practical Guide for Primary Care	✉ Abnormality on examination (screen all joints) ✉ Delay or regression in developmental milestones ✉ Widespread pain (e.g. upper limbs and back)	Community Paediatrics if developmental concerns
	ACUTE JOINT PAIN / STIFFNESS	Concerns regarding Non-Accidental Injury see Safeguarding / Child Protection section.	☎ History of trauma refer to CED ☎ History suggestive of joint inflammation	
	HYPERMOBILITY	Provide reassurance and advice leaflet to parent and Young People. Most do not require referral as falls within the normal range. **Patient Information leaflet** Hypermobility	✉ Severe, affecting function – physio may be helpful ✉ Associated fragile skin tissue, stretchy skin or family history of genetically confirmed Ehlers-Danlos Syndrome	Physiotherapy General Paediatrics
	MINOR ORTHOPAEDIC ANOMALIES	Check for spina bifida / neurological abnormality **Patient Information leaflet** Common Orthopaedic Problems Flat feet Intoeing gait Knock Knee	✉ refer Paediatric Physio/Orthopaedics if: • Condition is obviously asymmetrical • Condition is clearly progressive • Condition is associated with pain	Not appropriate unless evidence of spina bifida, neurological abnormality e.g. cerebral palsy

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
	CONCERN RE DEVELOPMENTAL DISLOCATION (DYSPLASIA) OF HIP	If hip instability or dislocatable refer urgently to Paediatric Orthopaedics. If > 6 months send for X-ray before referral. If reported normal = DDH is excluded.		Paediatric orthopaedics
	TORTICOLLIS	**Parent Leaflet** Head Turning Preference and Plagiocephaly	☎ Neonatal torticollis is likely to require urgent physiotherapy - referral via paediatrics ☎ In older children new onset torticollis can be a sign of raised intracranial pressure or cervical spine instability	General paediatrics
NEUROLOGICAL	AFEBRILE SEIZURES	ECG to rule out prolonged QTc, if possible. Give parents first aid advice on what to do in event of further episodes. Children and young people presenting with a suspected seizure should be seen by a specialist in the diagnosis and management of the epilepsies within two weeks of presentation. Children and young people who describe clear vasovagal prodromal symptoms prior to brief tonic clonic movements likely to be vasovagal rather than	☎ < 18 months ☎ New neurological signs or GCS (or equivalent) <15 (>1 hour posts seizure) ☎ Seizures presenting acutely with duration >10 minutes, focal, recurrent or required emergency treatment ☎ High parent or carer anxiety despite reassurance ☎ Seizures are in keeping with an epilepsy requiring urgent inpatient management e.g. infantile spasms (brief symmetrical flexor, extensor or mixed spasms often in clusters associated with developmental arrest / regression)	General Paediatrics (convulsive or nocturnal seizure) Mark referral as **urgent** (2-week pathway)

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
		epilepsy. Please see 'Unexplained Collapse' as possible appropriate alternative pathway.		
	TICS	**Patient information leaflet** TICS leaflet	✉ Persistent ✉ Distressing child / young person or family ✉ Any concerns regarding epilepsy or abnormal neurology needs medical assessment.	SPOA if persistent or distressing General paediatrics
	HEADACHE	Please see NICE CKS Headache guidance and Headsmart for quick reference for concerning associated symptoms Check BP and if you suspect hypertension please refer accordingly. Ask family attend for eye test and to keep headache diary ○ frequency, duration and severity of headaches ○ any associated symptoms ○ all prescribed and over the counter medications taken to relieve headaches (consider medication overuse headache) ○ possible precipitants ○ relationship of headaches to menstruation	☎ Sudden-onset thunderclap headache ☎ New - onset neurological deficit, cognitive dysfunction or change in personality, school performance ☎ Headache triggered by cough, valsalva (trying to breathe out with nose and mouth blocked) or sneeze ☎ Orthostatic headache (headache that changes with posture) ☎ Recent (typically within the past 3 months) head trauma ☎ Abnormal head position such as wry neck, head tilt or stiff neck ☎ Abnormal eye movements, blurred vision ☎ Seizure	General Paediatrics (if NICE guidance advises assessment)

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
		Headache post-concussion not requiring acute referral follow Return to Activities advice (C&YP require an extended period rest to avoid short and long-term health problems)		
NUTRITION	FUSSY DIET	Plot growth on growth chart; see UK90 chart. Refer health visitor or school nurse (Toddler forum leaflets) Gather information about concerns from other services involved e.g. nursery, school, CAMHS. Consider Early Help Assessment for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council	✉ Faltering growth ✉ Evidence of significant nutritional deficiency not responding to treatment as described in sections below ✉ Evidence / concerns of underlying gastrointestinal disorder (If concerns re Eating disorder or Autism please see sections in Behavioural / Emotional and Wellbeing Concerns)	General Paediatrics
	ANAEMIA OR CLINICALLY ANAEMIC	If anaemia picked up on blood testing and clear dietary reason for iron deficiency, treat with iron until the haemoglobin has normalised and then for 3 further months to replenish the iron stores. **Patient Information** Iron deficiency anaemia	✉ Iron deficiency without a clear reason ✉ Other medical symptoms ✉ Persistent despite treatment	General Paediatrics

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
	VITAMIN D DEFICIENCY OR CONCERNS ABOUT VITAMIN D DEFICIENCY	See JAPC Vitamin D Deficiency guideline. **Patient Information** Vit. D deficiency	✉ Rickets ✉ Associated long term illness e.g. renal/liver disease / malabsorption ✉ Abnormal Ca / PO4 / ALP ✉ Failure to respond to treatment after 4-8 weeks and compliance good (Delayed walking - see Motor Delay in Development section).	General Paediatrics
PUBERTY	PRECOCIOUS PUBERTY		✉ Disordered Puberty ✉ Onset before 9 years (boys) or 8 years (girls)	General Paediatrics
	DELAYED PUBERTY		✉ No evidence puberty by 13 years (girls) or 14 years (boys)	General Paediatrics
	BREAST DEVELOPMENT Symmetrical or Asymmetrical	**Patient Information leaflet** Gynaecomastia	✉ Pre-pubertal (but outside neonatal period) ✉ Significant psychological or physical distress ✉ Suspected associated pathology e.g. Klinefelter syndrome, hyperthyroidism or drug induced	General Paediatrics
RENAL	UNEXPLAINED HAEMATURIA OR PROTEINURIA	Culture and treat if dipstick suggests UTI For persistent microscopic haematuria, it is useful to dipstick both parents' urine as well.	☎ Clinical picture suggests nephritis or nephrotic syndrome ☎ Heavy proteinuria (3+/4+) ☎ Evidence of oedema/ fluid overload or hypovolaemia	

Category of problem	Detail of problem	**Action required prior to referral** **Alternative avenues suggested**	**Clinical concerns that may warrant ☎ urgent telephone advice or ✉ paediatric outpatient referral**	**Referral Advice**
			☎ Hypertension ✉ Persistent low grade	General Paediatrics
	HENOCH SCHÖNLEIN PURPURA (HSP)	Please see local HSP guideline. Urinalysis **Exclude other causes of purpuric rash carefully – if unsure refer acutely ☎** (e.g. Meningococcal septicaemia, disseminated intravascular coagulopathy, Acute Lymphocytic Leukaemia, Idiopathic Thrombocytopenic Purpura, Non-Accidental Injury, other vasculitides) **Patient information leaflet** HSP leaflet	☎ Diagnostic uncertainty ☎ Febrile / Tachycardia ☎ Any Haematuria or proteinuria on dipstick ☎ Hypertension ☎ Significant arthritis / arthralgia / abdominal pain not improved by Paracetamol ☎ Blood per rectum or acute testicular pain should be referred to Paediatric Surgeon	Call CED for rapid access clinic appointment, or acute review as needed.
RESPIRATORY CKS – NICE Asthma CKS – NICE Cough acute with chest signs in children CKS – NICE Croup CKS – NICE Whooping Cough	PRESCHOOL • Recurrent Wheeze • Recurrent LRTI • Persistent cough > 3 months	Oral steroids are not usually indicated in pre-school wheeze Optimise home environment with advice and support to parents to stop smoking (not smoking in front of the children is of no benefit). If a trial of inhaled corticosteroid or montelukast is considered this should be stopped after 4-8 weeks to see if symptoms resolved.	☎ Haemoptysis ☎ Oral steroids felt to be required ☎ Fixed wheeze, stridor, asymmetrical signs ☎ Signs of cardiac disease ✉ Clubbing ✉ Neonatal onset ✉ Cough with feeding ✉ Night sweats ✉ Weight loss ✉ Requiring more than 2 courses of antibiotics in 6-month period or severe, unusual or recurrent infections	General Paediatrics

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		Please also see local "Wheezy Child" guideline.	✉ Persistent night time symptoms ✉ Persistent wet cough ✉ Strong personal or family history of atopy ✉ Symptoms persist despite 4-8 week trial of inhaled corticosteroid or montelukast	
	SCHOOL AGE ASTHMA	Optimise home environment with advice and support to parents to stop smoking (not smoking in front of the children is of no benefit) If symptoms controlled treatment should be reduced to minimum level that symptoms still controlled Useful Summary Management of Asthma GP CKS – NICE Asthma BTS/SIGN Guideline summary Please also see local "Wheezy Child" guideline.	☎ Haemoptysis ☎ Fixed wheeze, stridor, asymmetrical signs (Do not treat with steroids) ✉ Diagnostic doubt ✉ Failure to respond adequately to a low to medium dose of inhaled corticosteroids ✉ Required 2 doses oral corticosteroids in a year ✉ Neonatal onset ✉ Cough with feeding ✉ Night sweats ✉ Weight loss / faltering growth ✉ Clubbing ✉ Strong personal or family history of atopy ✉ History of severe, unusual or recurrent infections	General Paediatrics IgE mediated – General Allergy Clinic
	SLEEP DISORDERED BREATHING (SNORING WITH	✉ ENT referral Paediatric review required if clinical concerns as listed. ENT referral may be appropriate at the same time	✉ Age <2 years ✉ Down syndrome ✉ Cerebral palsy ✉ Hypotonia or neuromuscular disorders	General Paediatrics Community

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	PERIODS OF APNOEA)		✉ Craniofacial anomalies ✉ Mucopolysaccharidosis ✉ Obesity (BMI >99th centile for age and gender) ✉ Significant comorbidity such as congenital heart disease, chronic lung disease	Paediatrics (via SPOA) if there are concerns about development
SAFEGUARDING / CHILD PROTECTION Please see CKS - NICE Child Maltreatment	SUSPECTED PHYSICAL ABUSE INCLUDING BRUISE IN A NON-MOBILE BABY	☎ Immediate referral to Children's Social Care ➢ City - **01332 641172** ➢ County - **01629 533190** Follow local safeguarding procedures. **Please see CKS - NICE Child Maltreatment** If not reaching threshold for CSC referral consider Early Help Assessment / Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council	☎ If acute injuries requiring immediate medical attention arrange ambulance transfer to Emergency Department (inform senior in ED) and refer to children's social care	
	NEGLECT OR EMOTIONAL ABUSE	**Please see CKS - NICE Child Maltreatment** Follow local safeguarding procedures.		

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		If not reaching threshold for CSC referral consider Early Help Assessment / Starting Point referral for early help and parenting support ✓ Derbyshire County Council ✓ Derby City Council		
	SUSPECTED CHILD SEXUAL ABUSE	**Please see CKS - NICE Child Maltreatment.** Indicators of sexual abuse include: • Sexualised behaviour inappropriate to stage of development • Unexplained vaginal bleeding – absence of appropriate history of accidental trauma or history of trauma but bleeding point not visualised on external genitalia • Child is a perpetrator of sexual abuse • STI including genital warts • Pregnancy in a child • Foreign Body in Vagina or Anus ☎ Immediate referral to Children's Social Care (LSCB procedures) (LSCB Contacts) Social Worker will arrange appropriate medical assessment. **Derby** First Contact Team	☎ If acute injuries requiring immediate attention arrange ambulance transfer to Emergency Department (inform senior in ED) and refer to children's social care ☎ If medical condition requiring urgent treatment e.g. PV bleeding, STI, concerns regarding pregnancy please also speak directly to on call paediatrician for child sexual abuse **01332 623730** (Out of Hours 01332 623700)	

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		Tel: 01332 641172 (Out of Hours - **Tel:** 01332 786968) **Derbyshire** Starting Point **Tel**: **01629 533190** (Out of Hours - **Tel**: 01629 532 600)		
SENSORY IMPAIRMENT	CONCERNS ABOUT HEARING	If wider concerns about development please also refer to section on Development.	✉ Audiology (Community Paediatrician may become involved after hearing concerns defined).	Audiology
	CONCERNS ABOUT VISION	If wider concerns about development please also refer to section on Development. If concerns regarding Squint please see CKS – NICE Squint	✉ High street Optician if > 3 years refer Ophthalmology for younger children ☎ Suspected blindness in a baby needs URGENT Ophthalmology referral	
SLEEP CONCERNS See Respiratory for Sleep Disordered Breathing (Snoring with periods of apnoea)	PRE-SCHOOL SETTING/ NIGHT WAKING/ NIGHTMARES/ NIGHT TERRORS/ SLEEP WALKING OR TALKING	Refer to Heath Visiting or School Nursing teams who can offer other support Parent Information Sleep Council	✉ Associated medical issues e.g. sleep disordered breathing ✉ Associated Neurodevelopmental concern – refer to SPOA ✉ Suspected neurological sleep disorder e.g. Narcolepsy	ENT SPOA – form here. General Paediatrics