

Criteria for referral to Clinical Haematology at UHB (HGS)

If unsure or not meeting criteria for referral please use Advice and Guidance and/or Consultant connect for advice regarding whether the patient needs a haematology referral.

Referral category	Suggested tests/causes	Criteria for urgent HEFT referral	Criteria for HEFT routine referral (persistent=on ≥ 2 occasions at least 6 weeks apart)
Anaemia (Hb <133 g/l males, <110 g/l females) <i>If Iron deficient refer to gastroenterology or gynaecology as appropriate</i>	Detailed history, blood film, reticulocytes, haematinic assays, assays for paraprotein, renal function	Leucoerythroblastic film, unexplained progressive symptomatic, enlarged spleen or lymph glands	Persistent unexplained anaemia, intolerance to at least 2 oral iron supplement preparations (or) suboptimal response to iron. B12 deficiency (B12 <lower limit of lab range) + no evidence of pernicious anaemia.
Erythrocytosis Is judged on basis of HCT.	Repeat, alcohol/smoking, glucose, drugs,	HCT >♂>0.60 or ♀>0.56 Recent thrombosis, neurological symptoms	Persistently elevated HCT ♂>0.51 or ♀>0.48 (lower if associated iron deficiency). Associated itch or \uparrow WBC / Platelets
Haemochromatosis/ Elevated ferritin	Inflammatory markers, alcohol status, liver tests, glucose, transferrin saturation.	Evidence of cardiac, liver or endocrine damage	Persistent unexplained raised ferritin with Transferrin saturation >45%, genetic counselling of relatives.
Haemoglobinopathy Sickle cell disease and thalassaemia	FBC, Hb Electrophoresis (essential), renal and liver function.	Acute presentation of severe pain, acute chest syndrome, stroke or priapism should be referred directly to A+E	Refer the following to the Regional Haemoglobinopathy centre at City Hospital for routine care. Once assessed there, HEFT can have a shared care of the patients if recommended by City Hospital - Sickle cell disease (HbSS, HbSC, HbSBthalassaemia, HbSD, HbSE, HbS-OArab) B thalassaemia major , B thalassaemia intermedia; HbH disease.
Lymphadenopathy	FBC, glandular fever, HIV test, monitoring	As per 2 week wait criteria: >1cm for >6 weeks; <6 weeks + B symptoms (unexplained fever >37.5°C, weight loss >10% body weight over 6 months, drenching night sweats); enlarging/>1 site, hepatosplenomegaly, abnormal FBC	Persistent lymphadenopathy not meeting urgent criteria

Lymphocytosis	Glandular fever screen if appropriate, repeat, smoking history	Anaemia, ↓ANC, ↓platelets, splenomegaly, painful /progressive lymphadenopathy, B* symptoms	Persistent lymphocytes > 5 x10 ⁹ /L, not meeting urgent criteria
Macrocytosis Treat B12/folate deficiency before referral. Non-complex pernicious anaemia does not need review	Blood film/B12/folate (IF /coeliac antibodies if abnormal), alcohol/liver/thyroid screen	Associated neurological symptoms	Persistent unexplained MCV>105fl or ↓WBC or platelets; Suspected myelodysplasia. B12/FOLATE DEFICIENCY PATIENTS DO NOT NEED REFERRAL. APPROPRIATE SUPPLEMENTATION IN PRIMARY CARE AS PER BNF
Neutropenia	Review ethnicity + drugs, blood film, autoimmune screen	Susceptibility to infection, associated pancytopenia	Unexplained and persistently low <1 x10 ⁹ /L or <1.5 and falling. (<0.8 in patients of African, Caribbean or Far East Ethnicity)
Neutrophilia Eosinophilia	Blood film, inflammatory markers, smoking /allergy/atopy status	Leucoerythroblastic film, absolute neutrophil count > 50 x10 ⁹ /L, absolute eosinophil count > 10 x10 ⁹ /L >100 or clinical features of ↑viscosity- by phone	Persistent, unexplained WBC >11-20 x10 ⁹ /L, Neutrophils >15 x10 ⁹ /L Eosinophils >1.5 x10 ⁹ /L
Paraprotein disorders ie presence of monoclonal protein band on serum electrophoresis	FBC, renal and bone profile.	Presence of ↑calcium, ↑ lymphocytes unexplained renal failure, bone pain or pathological #, ↑viscosity, enlarged spleen/lymph glands Suspected spinal cord compression- by phone	Newly diagnosed paraprotein not meeting criteria for urgent referral. DO NOT REFER TO HAEMATOLOGY FOR POLYCLONAL RISE IN IMMUNOGLOBULINS. THIS IS BODY'S NORMAL RESPONSE TO UNDERLYING INFECTION/INFLAMMATION.
Thrombocytopenia 100-150 x10⁹/L : Monitor in primary care every 4-6 months	Blood film, autoimmune profile, alcohol history, drug review, HIV test, repeat for persistence	Platelets <50 x10 ⁹ /L or 50-100 with other cytopenia, spleen/ lymph glands, pregnancy, surgery <20 / active bleeding- by phone	Persistent <100 x10 ⁹ /L (<80 in patients of African, Caribbean ethnicity; history of thrombosis
Thrombocytosis	Blood film, iron status, inflammatory markers	Platelets >1000 x10 ⁹ /L or >600 recent thrombosis/bleed	Persistent, unexplained platelet count >450 x10 ⁹ /L