

# MEDICAL NEUROLOGY



## National Access Criteria (Bay of Plenty Variation) First Specialist Assessment [FSA]

### Category Definition:

**Emergencies** : Immediate In patient neurology.

### Waiting Times:

Urgent OPD grade 1  
Semi Urgent OPD grade 2p  
Routine OPD grade 2  
Unable to be seen OPD grade 3  
Neurophysiology See below

Category	Signs or symptoms	Examples ( <i>not an exhaustive list</i> )	Local notes
<b>EMERGENCIES</b>			
<ul style="list-style-type: none"> <li>▪ <b>Immediate assessment via ED and medical teams</b></li> </ul>	<ul style="list-style-type: none"> <li>• Sudden onset life threatening conditions</li> <li>• Persistent loss of consciousness</li> <li>• Signs of raised intracranial pressures</li> <li>• Rapidly evolving paralysis any distribution, any cause, with or without respiratory difficulty, loss or disturbance of sphincter functions</li> <li>• Sudden severe first ever headache</li> </ul>	<ul style="list-style-type: none"> <li>▪ Stupor and coma/ acute confusional states eg suspected encephalitis</li> <li>▪ Subarachnoid haemorrhage</li> <li>▪ Myasthenia gravis,</li> <li>▪ Guillain-Barré syndrome</li> <li>▪ Spinal cord compression/cauda equina syndrome</li> <li>▪ Meningitis</li> <li>▪ Stroke</li> <li>▪ Status epilepticus</li> <li>▪ Serial TIA's with high ABCD2 score</li> </ul>	<p>Neurological problems requiring <i>urgent assessment or admission</i> should be referred to <i>the medical team of the day or the emergency department</i>.</p> <p>There is no acute specialist neurology service at TPH.</p> <p>Please make use of the TIA guidelines.</p>

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<b>OUTPATIENT REFERRALS</b>			
<ul style="list-style-type: none"> <li>▪ <b>Urgent (OPD grade1)</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Any sub acute evolving or episodic neurological dysfunction with a potential for serious neurological impairment (usually over days to weeks).</li> </ul>	<ul style="list-style-type: none"> <li>▪ Recurrent seizures not needing admission</li> <li>▪ Focal neurological disturbances</li> <li>▪ Acute cranial nerve palsy such as optic neuritis, diplopia.</li> <li>▪ Idiopathic intracranial hypertension or other headache with relevant neurological <i>signs</i></li> <li>▪ New onset headache with neurological signs</li> </ul>	<p>In the absence of a neurologist due to leave, the physician on call should be contacted for advise</p>
<ul style="list-style-type: none"> <li>▪ <b>Semi – Urgent (grade ‘2p’ priority)</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Progressive loss of neurological function (slower rate than 2)</li> <li>▪ Unsteadiness, poor balance without identified cause</li> <li>▪ Dysphagia</li> <li>▪ Cognitive impairments (especially less than 65 years)</li> <li>▪ Hyper and hypo kinetic movements</li> </ul>	<ul style="list-style-type: none"> <li>▪ Symptoms suggestive of: multiple sclerosis; neuropathies; myopathy; motor neuron disease</li> <li>▪ Isolated seizures, transient amnesia</li> <li>▪ Trigeminal neuralgia</li> <li>▪ Parkinsonism</li> <li>▪ Functional disorders, with abnormal examination - suspected somatisation disorder</li> </ul>	<p>The better the referral history and examination findings the more likely the patient is to be seen appropriately. This especially means copies of prior specialist reviews.</p>
<ul style="list-style-type: none"> <li>▪ <b>Routine (grade 2)</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Chronic neurodegenerative disorders: acquired or inherited (slow rate of progression or long history)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Suspected Alzheimer’s disease or other dementias</li> <li>▪ Intellectual handicap, cerebral palsy not graded elsewhere</li> </ul>	<p>The key ingredients in your referral letters are the nature of the <i>symptoms</i>, their mode of onset and their time course.</p>
<ul style="list-style-type: none"> <li>▪ <b>(grade 3)</b></li> </ul>		<ul style="list-style-type: none"> <li>▪ Primary headache including migraine and muscle tension headache</li> <li>▪ Episodic isolated vertigo</li> <li>▪ Simple Syncope</li> <li>▪ Dizziness not otherwise specified</li> <li>▪ Limb pain, neck, back pain or other chronic pain without neurological signs</li> </ul>	<p>ACC issues: The GP should ask the ACC to refer for a neurological opinion. The ACC case manager will usually chose a private provider.</p> <p>Insurance, driving and other medico-legal type reports are not seen in public hospital clinics.</p>

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		<ul style="list-style-type: none"> <li>▪ Fatigue NOS</li> <li>▪ Elderly neuropsychiatry</li> <li>▪ Second, third and subsequent neurological opinions</li> <li>▪ Screening for aneurysms</li> </ul>	
<b>Referrals for Neurophysiological Investigations</b>		<p><b>Nerve conduction studies and EMG</b>            Will be accepted from general practitioners, e.g.            Possible CTS, as long as waiting time remain &lt; 6 months.            These will be graded, depending on the setting, by consultant staff as a) Priority or b) routine</p> <p>ACC cases not performed at TPH (private providers, Hamilton).</p>	<p><b>EEG</b>            Usually performed in conjunction with an outpatient clinic or referral. Occasional EEG requests from General Practitioners will be performed without a clinic visit if this seems appropriate, based on the referral. See EEG request form for indications for EEG</p>

### Additional Notes:

- *All referral letters received by the neurology outpatient clinic for assessment undergo triage by a consultant neurologist and a prioritisation number is applied as above.*
- *While the prioritisation process in specialties other than neurology is often based on what the referral diagnosis is, this has never been a particularly useful criteria in neurology, as the reason for referral is often that the cause of the patient's symptoms are not known. Thus, the key ingredients in your referral letters that determines the prioritisation in many instances, **is what the nature of the symptoms are, their mode of onset and the time course of them.***
- *Indicating in your letter that a patient has previously attended the clinic can make a difference to the arrangements we make, as the patient may then be regarded as a follow up case for which the waiting time may be shorter than if the patient is enrolled as a new case. If your patient has previously been seen by one of the neurologist and you are able to state which one in your letter, this also facilitates the prioritisation process.*
- *You are encouraged to consider referral of elderly patients (80 years plus) with neurological problems to Elderly Care Services physicians in the first instance.*
- *The more you can do to follow up patients and carry through recommendations, the more time we have to see new cases, the balance between new and review case time is difficult to satisfy all.*
- *Pediatric neurology is normally dealt with by the Pediatricians with referral to pediatric neurologists as appropriate*
- *Neurosurgical referrals may go directly to Waikato Hospital – e.g. for re-scanning/follow up of cerebral tumours, treatment of recognized intracranial aneurysms.*