Criteria for referral to Clinical Haematology at HEFT

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/lt males, <110 g/lt females) ***If Iron deficient refer to gastroenterology or gynaecology as appropriate***	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 ↑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^{o}, 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 $x10^9$/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