# Children's Physician Group–Gynecology

## Guidelines for referrals

Below is a list of guidelines to follow when referring a patient for a consultation to Children's Physician Group–Gynecology. These are meant to be general recommendations. If you have specific questions, call **404-785-DOCS (3627)** and ask to speak with the on-call gynecologist.

### Common conditions treated

- Abnormal uterine bleeding
- Adnexal masses (ovarian/paraovarian cysts)
- Amenorrhea
- Complex contraception (pregnancy prevention in medically complex patients)
- Congenital adrenal hyperplasia
- Delayed puberty
- Disorders of sex development
- Dysmenorrhea
- Endometriosis
- Gender affirming care
- Hormone replacement therapy
- Menstrual suppression for special needs
- Mullerian (uterine) anomalies
- Pelvic inflammatory disease
- Precocious puberty
- Premature ovarian insufficiency
- Polycystic ovarian syndrome
- Urethral prolapse
- Vaginal anomalies
- Vulvar vaginal issues
    - Vaginal discharge
    - Prepubertal vulvovaginitis
    - Labial/vulvar masses and ulcers
    - Lichen sclerosus
    - Labial adhesions
    - Labial hypertrophy
    - Genital tract trauma

For patients with the conditions listed below, we recommend a referral to our Adolescent Medicine Clinic, located at Hughes Spalding Hospital (phone: 404-785-9850), or an external gynecology provider.

- **New patients >16 years**: irregular periods, vulvovaginitis, contraceptive counseling, dysmenorrhea
- **Return patients >16 years**: controlled symptoms and no complex medical issues

### Urgent referrals

Most issues we see do not warrant an urgent referral. However, if you feel your patient needs to be seen as soon as possible, note "urgent" on your referral. All referrals marked "urgent" are triaged to help make sure patients are seen in a timely fashion. If you wish to speak to the on-call pediatric gynecologist, call 404-785-9635. Generally, conditions that may warrant an urgent initial outpatient visit include, but are not limited to:

- Ovarian, pelvic, adnexal masses
- Acute genital tract trauma
- Differences of sexual development
- Vaginal/menstrual outflow tract obstruction

### Routine referrals

The majority of conditions we see may not warrant an urgent evaluation given the available resources. These may include, but are not limited to, the following:

- Heavy menses
- Irregular or abnormal menstrual bleeding
- Painful menses (dysmenorrhea, endometriosis, pelvic pain NOS)
- Vaginal discharge or pain
- Precocious puberty
- Delayed puberty
- PCOS

## Referral checklist and guidelines for common diagnoses

**When referring a patient for any reason, except transgender care, you must include office notes. Otherwise, we will not be able to schedule your patient.** In the table below, we have listed the labs and/or documents we require for the most common referrals. If the suspected diagnosis is not listed below, you only need to include office notes and labs that have already been ordered.

| Suspected diagnosis | Labs/documents required before scheduling | Criteria for referral | Suggested work-up | Possible initial management |
|---|---|---|---|---|
| Heavy menses | □ Office notes<br>□ Lab results if ordered | Bleeding >7days, >7 pads per day, menses resulting in anemia | • CBC<br>• Von Willebrand panel<br>• Fibrinogen<br>• TSH<br>• Iron studies | ***Aygestin; combined oral contraceptive pill (OCP); consider the risk for thrombosis before starting OCP* |
| Precocious puberty | □ Office notes<br>□ Growth curve<br>□ Lab results if ordered | Breast, genital hair, vaginal bleeding prior to age 8 | • LH<br>• FSH<br>• Estradiol<br>• TSH<br>• Prolactin | |
| Delayed puberty | □ Office notes<br>□ Growth curve<br>□ Lab results if ordered | No pubertal development by age 13 | • LH<br>• FSH<br>• Estradiol<br>• TSH<br>• Prolactin | |
| Primary amenorrhea | □ Office notes<br>□ Growth curve<br>□ Lab results if ordered | No menses by age 15 or 3 years after menarche | See irregular menses workup | |
| Irregular menses, oligomenorrhea, Polycystic Ovarian Syndrome (PCOS) | □ Office notes<br>□ Growth curve<br>□ Lab results if ordered | Irregular or absent bleeding<br><br>Do labs if any androgenizing symptoms (acne, hirsutism) | • LH<br>• FSH<br>• Estradiol<br>• 17-hydroxy-progesterone<br>• Free testosterone<br>• DHEA-S<br>• TSH<br>• Fasting complete metabolic profile<br>• Fasting lipid profile<br>• hCG (urine or serum)<br>• Prolactin | OCP is the first line of therapy; consider the risk for thrombosis before starting OCP*<br><br>Metformin is used by some, but it is not an FDA-approved indication |
| Pelvic mass | □ Office notes<br>□ Imaging report* | We must have imaging report prior to scheduling appointment | • Patient to bring disc with images | |
| Dysmenorrhea | □ Office notes<br>□ Imaging if done | | | Ibuprofen 600mg TID; heating pads, warm bath, physical activity |
| Complex contraception | □ Office notes<br>□ Lab results if ordered | Patient has underlying medical problem that would prohibit adolescent medicine or general GYN from providing care | • Gonorrhea<br>• Chlamydia<br>• Trichomonas<br>• +/-RPR and HIV | |

*AUB labs should be drawn **before** starting hormone therapy, if indicated.

***Initial therapy in patient with heavy menstrual bleeding that is actively bleeding

- Taper if hgb 8-11.9 and actively bleeding:
  - Aygestin 10mg BID x3 days until 3 days after bleeding stops then continue 10mg daily OR
  - Orthocyclen 1 tab q8 hours x3 days, then BID x2 days, then daily
- Maintenance if hgb >11.9 or not actively bleeding:
  - Aygestin 10mg daily OR
  - Orthocyclen 1 tab daily (may skip placebo week)
- Send to Emergency Department for active bleeding (not spotting) and hgb <8

## Growth curves

We require growth curves for all referred patients prior to scheduling. Note, it is very important to provide a **visual line graph**, ideally for both height and weight, although both are not required. Multiple points are preferred, *if available*. If you have only seen the patient once, we will accept graphs with single points.

**Figure A**

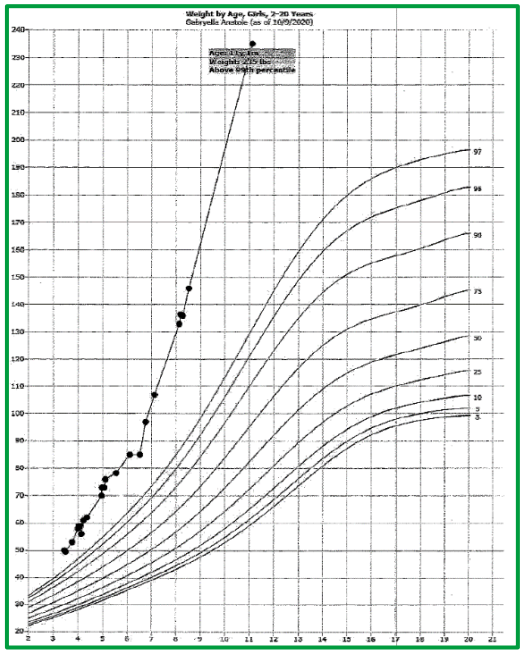

**Figure B**

| Vitals with Age-Percentiles | 8/11/2016 | 12/15/2016 | 7/20/2017 | 4/20/2018 | 4/20/2018 | 6/20/2019 | 6/20/2019 | 7 |
|---|---|---|---|---|---|---|---|---|
| Height percentile | | 84.1 % | 79.1 % | | 60.5 % | | 66.9 % | |
| Systolic percentile | | | | | | | | |
| Diastolic percentile | | | | | | | | |
| Weight percentile | 38.2 % | 39.4 % | 32.7 % | | 61.3 % | | 42.6 % | |
| Head Circumference percentile | | 98.4 % | | | | | | |
| Length | | 95.3 cm | 99.1 cm | | 102 cm | | 114.5 cm | |
| Systolic | | | 90 | | 94 | | 90 | |
| Diastolic | | | 58 | | 50 | | 62 | |
| Head Circumference | | 20.250 | | | | | | |
| Pulse | | | | | | | | |
| Weight | 27 lb | 28 lb 6.1 oz | 30 lb | | 36 lb 4 oz | | 39 lb 6.1 oz | |
| Body Mass Index | | | | 15.6 kg/m2 | | 13.63 kg/m2 | | |
| Body Mass Index percentile | | 5.7 % | 4.3 % | | 66.0 % | | 6.8 % | |
| BODY SURFACE AREA | | | | 0.68 | | 0.75 | | |

## Office notes

Office notes are crucial in helping us determine the intricacies of your patient's case. Note, we require office notes *beyond* just the reason for referral. Whether you refer to them as Clinical Notes, History of Present Illness (HPI), Interval History or Notes, what we need are notes that the provider took during the last visit that explain the child's case and chief concern. A short "reason for referral" is **not** sufficient. See examples below.

**Insufficient**

**Referral**
**Date Requested:** 08/16/2021
**Requested by:** anastasiya drogoul, NP
**Referral To:** Pediatric Endocrinology
**Summary of Care Provided**
**Reason for Referral/Notes:** breast buds and pubic hair
**ICD Code:** Precocious puberty (ICD-10: E30.1)

**Sufficient**

[redacted] is a 15-year-old female seen for follow-up visit via telemedicine with video for anxiety depression and gender identity issues.

Gender identity: [redacted] aunt called for a crisis appointment as [redacted] was getting very distressed about having breast and wanted her breast removed when she went clothes shopping with her family. [redacted] reports that since 13 years of age she has never liked her body does not like being a female is always identified as being a boy gets jealous when she sees boys. Reports that recently it has gotten unbearable and does not want people to perceive her as a girl so she avoids going in social settings. Reports that her symptoms worsened when she hit puberty and started developing a female body.

She would like to transition and talk about what it entails to transition to a boy. Reports that her family is very supportive and want her to be happy.

Anxiety and depression:Reports that overall her mood has been stable is not having any tantrums or emotional outburst. Reports that she has been sleeping well, continues to have her imaginary friends however is able to disengage and focus on her schoolwork. She is planning to go to the regular public school. Denies any self-harm or suicidal thoughts.

Insomnia:Reports improved sleep with clonidine 0.1 mg at night.

Menarche 11/20. Cycles have been very heavy with clots, uses 5-6 pads/day. Cycles last 2-4 weeks
Asthma -mild persistent. On Ventolin HFA prn and Flovent daily. Needs refills