

Dear General Practitioners,

**Conversation Club:** The next opportunity for wine, cheese and conversation with specialists is on June 16<sup>th</sup>, 5-6pm. Please note, there is going to be a change of venue to the **Hospital management room** which is in the old hospital building opposite the mammography cottage. Pim Allen (Chief Medical Officer) and I would like to see you there.

Recently I attended a meeting of local **Pharmacists and the Police** who were discussing pseudoephedrine shoppers, and the systems they have in place to catch them. Apparently small amounts of pseudoephedrine containing products can make significant amounts of P. The pharmacists have a system, faxing information about these shoppers to each other, which is working well. One of my patients was observed to be buying frequent amounts of codeine products from a variety of pharmacies. They used this system to let me know. This has been very helpful in my dealings with the patient. I asked if there were other ways GPs could help reduce the risk of illegitimate use of these products when we prescribe them (especially codeine) in a huge variety of doses. It was suggested that when we prescribe the tablets as 1-2 prn to q4h we put a finite number on the script. If we just leave it at one or three months' prescription they can end up getting hundreds of tablets which may or may not be needed. We are better to put a fixed number of tablets, with repeats if necessary.

**Scoping update:** Southland hospital has caught up with surveillance colonoscopies with the colonoscopy project and by outsourcing 200 to Southern Cross. Many surveillance scopes are recommended to be done at 3-5 year intervals. Because of pressure on resource we have organised for these to be done 5 yearly. It is inevitable that some patients will develop pathology in that time so please refer (or re-refer) patients who develop symptoms or signs of bowel disease while waiting for a "surveillance" scope. Version 2 of the proforma Julian Speight suggests we use for referring patients is available on [sdhb.govt.nz](http://sdhb.govt.nz) You only have to put the patient details on, tick one box and send it in. Mail to the hospital is the preferred way.

**All Referrals** are better sent hard copy (not fax) to the hospital at this stage, and if they are urgent, please phone the hospital and talk with someone who can take responsibility for the patient being seen urgently. We are working on electronic referrals, but e-discharges will come first. The Information Service team is working towards having electronic discharges later this year, and will move to e-referrals after that.

Dr Hodges, **respiratory** physician, has left and his replacement has not yet arrived. Otago will provide acute and elective bronchoscopy services so patients in whom this is likely to be required should continue to be referred, but referral of chronic problems are unlikely to be seen urgently. If a referral is required, please address it to the Respiratory service and it will be triaged by Dr Alasdair Millar. He says he will request the CT for patients who present with an abnormal chest xray showing a suspicious lesion on condition that the formal CXR report is included. This gives him the option to defer or not according to the urgency or degree of positivity in the report, plus clinical signs if any (nodes, unexplained weight loss, that sort of thing).

Some of you will have been surprised at the **Sleep Apnoea proforma** and its request for handwritten results – use it as a guideline for what is useful information but we will work on a better way of collecting that information

**Ultrasound scans of shoulders** – the hospital does not accept GP referrals for shoulder ultrasound. If you have a patient that needs one (and is not eligible for an ACC funded one) you will have to refer them to an orthopaedic outpatient clinic. We are able to refer to private imaging providers if the patient can pay.

**The Hospice** has a new medical director, Dr Christian Robold, from Germany. His tenure is for 2 years at this stage and his wife and children are going to join him here in July

**Laboratory Update** Seminal fluid for fertility needs to be taken to the lab Monday to Friday before 3pm as it is time-consuming to test. If Saturday morning is the only day possible please arrange this with the microbiology department at Southland Hospital before the test is done.

**Estimated Waiting times for a First Specialist Assessment – May 2009**

Speciality	Priority	Estimated Wait
Audiology	All referrals	1-2 months
Cardiology	Urgent	14-16 weeks
	Semi-urgent	16-20 weeks
	Routine	6-8 months
Dental	Adult routine	6-12 months
	Child Routine	2-3 months
Dermatology	Urgent	4-8 weeks
	S-urgent	3-4 months
	Routine	6-8 months
Diabetes	Urgent	1 month
	Routine	4-6 months
Endocrinology		
ENT	Urgent	2-4 weeks
	S-urgent	7-8 months
	Routine	12 months
Gastroenterology Medical OP	Urgent	2-4 weeks
	Semiurgent	4-6 weeks
	Routine	6-8 weeks
Gastroscopy	A	4-6 weeks
	A/B	6-8 weeks
	B	8 months
	C	12 months
Colonoscopy	A	3-6 weeks
	A/B	3 months
	B	8 months
	C	12 - 18months
General Medicine		Now accepting referrals
Gynaecology	urgent	3-6 weeks
	S-urgent	2-4 months
	Routine	4-5 months
Neurology	Urgent	1-2 weeks
	S-urgent	2-6 weeks
	Routine	4-6 months

Speciality	Priority	Estimated Wait
Maxillofacial surgery	All referrals	No waiting list
Neurosurgery	Urgent	Within 1 month
	S-urgent	Within 1 month
	Routine	6 months
Ophthalmology	Urgent	1-2 weeks
	Semi-urgent	2-6 months
	S-urgent cataract	1-3 months
	Routine cataract	3-4 months
Orthopaedics	Urgent	0-3 months
	S-urgent	3-6 months
	Routine	12 months
Renal Medicine	Urgent	2-4 weeks
	S-urgent	2-3 months
	Routine	4-6 months
Paediatric surgery	Routine	1-2 months
Paediatrics Medical	Routine In'gill	5 months
	Gore	5 months
	Queenstown	3 months
Respiratory	Urgent	< 2 weeks
	Semi-urgent	2-8 weeks
	Routine	4-6 months
Rheumatology	Urgent	1-2 months
	Semi urgent	3-4 months
	Routine	4-6 months
Surgical Services	Urgent	Within 1 month
	S-urgent	2-3 months
	Routine	4-6 months
Urology	Urgent	1-3 weeks
	S-urgent	6-8 weeks
	Routine	3 months
Minor surgery	Urgent	4 weeks
	Semi-urgent	4-6 weeks
	Routine	3-4 months
AT and R	Urgent	< 4 weeks
	S-urgent	2-3 months
	Routine	< 6 months

Mental Health		
SMHET Invercargill Community Mental Health Team (ICMHT)		Same day triage Within two weeks
Rhanna		Contact made same day
CAFS		Urgent < 24hours Routine 1 month

Oncology		
Haematology	Urgent	7 days
	Semi-urgent	18 days
	Routine	33 days
Oncology	Urgent	0 days
	Semi-urgent	10 days
Radiotherapy	Urgent target	7 days
	Semi-urgent	3 weeks

Medical Imaging Waiting Times		
MRI	Urgent	Same day
	Semi-urgent	2-3 weeks
	ACC	16 working days
	Private	16 working days
CT	Routine	6 weeks
	Semi-urgent	1-2 weeks
	ACC	Within 10 days
	Private patients	Within 10 days
Ultrasound	Routine OP	4 weeks
Mammography	18-20 weeks	
Nuclear Medicine	Recall patients	8 weeks
	Urgent	1 weeks
	Urgent	2 week
	Semi-urgent	4 weeks
	ACC	10 working days
	Private	10 working days
X-ray appointments	Routine	4 weeks
	Cardiac scans	3 months
X-ray appointments	X-ray	18 weeks
	Urgent	please phone MRTs ext 8459
IVU	6 weeks	
Ba. F Thru / Ba Enemas	6 weeks	

Diagnostic testing		
ECGs, spirometry, arterial brachial indices, Ambulatory BPs	urgent	1 week
	semi urgent	2 weeks
	routine	4 weeks
Holters	urgent,	2-3 weeks
	semi-urgent	3-6 weeks
	routine	6-8 weeks
Echocardiograms	4-6 weeks (ref via Cardiology)	
Sleep studies:	6-8 weeks (ref via Respiratory)	
Nerve conduction studies	Refer to Peter Taylor at Windsor Specialist Centre and clearly mark whether private, public or ACC. 3 months	