Cardiac Inpatient Inter-hospital Transfer Guideline
For level 3–6 Clinical Services Capability Framework (CSCF) sites

The following criteria serve as a guide and should not replace expert clinical judgement or communication between sites. This guideline has been developed and endorsed by the Statewide Cardiac Clinical Network.

Level 1 and 2 CSCF sites:
Follow relevant Clinical Pathway, and early discussion with Cardiology ‘hub’ site with view to immediate (<12hr) transfer, except for Troponin (Tn) negative chest pain, which would follow local process.

Definition of target time:
Time between presentation at referring hospital and arrival at receiving hospital.

### Acute Coronary Syndrome

<table>
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| Immediate   | • Acute STEMI for primary Percutaneous Coronary Intervention (PCI)  
• STEMI post-thrombolysis (administer thrombolysis and send immediately)  
• Recurrent Ventricular Tachycardia (VT) / Ventricular Fibrillation (VF) post-Myocardial Infarction (MI)  
• Mechanical complication post-MI (MR / VSD / Cardiac Rupture)  
• Medically refractory high-risk Acute Coronary Syndrome (ACS)  
• Cardiogenic shock in patient suitable for intervention |
| 24 Hours    | • High risk NSTEACS patient with TIMI score >4  
• Recurrent post-infarct angina  
• Heart Failure post-MI  
• All other patients post-STEMI |
| 48 Hours    | • NSTEMI with Low (<4) TIMI / GRACE score (Tn +ve) |
| 72 Hours    | • Intermediate risk chest pain unable to be stratified with a functional study locally (Tn –ve / no ECG changes) |

### Electro-physiology

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| Immediate   | • Recurrent VT despite antiarrhythmic therapy or repeated ICD shocks  
• Arrhythmias with haemodynamic compromise (i.e. hypotension / heart failure / cardiogenic shock)  
• Bradycardia requiring a temporary pacing wire at regional hospital |
| 24 Hours    | • Bradycardia / heart block with IV infusion support at regional hospital  
• Suspected device malfunction  
• Ventricular Tachycardia |
| 48 Hours    | • Suspected device infection  
• Symptomatic bradycardia for permanent pacemaker implantation, not requiring temporary pacing wire or IV infusion support |
| 72 Hours    | • Symptoms suspected of arrhythmic origin, but no definite cause identified at initial presentation |
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## General Cardiology

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| **Immediate** | • Pericardial effusion with tamponade  
            • Acute pulmonary oedema (post stabilisation) with significant or suspected valve pathology  
            • Haemodynamically unstable mechanical valve prosthesis dysfunction - notify surgical team  
            • Endocarditis with severe valve regurgitation / suspected abscess  
            • Large pulmonary embolism with hemodynamic instability / limited cardiopulmonary reserve  
            • Presumed myocarditis / severe cardiac failure requiring inotropes  
            • Cardiogenic shock with increasing inotrope requirements (irrespective of aetiology) |
| **24 Hours** | • Severe AS with syncope, pulmonary congestion or Tn / CK elevation  
              • Presumed endocarditis for evaluation  
              • Presumed myocarditis with Ejection Fraction (EF) <30% |
| **48 Hours** | • Large pericardial effusion (no tamponade) for diagnostic evaluation  
              • Newly diagnosed heart failure with EF <20%  
              • Previously stabilised heart failure patient with EF <30% not tolerant of medical therapy |
| **72 Hours** | • Newly diagnosed heart failure EF <30%, stable but where advanced imaging modalities or biopsy are considered essential  
              • EF <30% recurrently hospitalised with decompensated heart failure with potential for advanced heart failure therapies |

## Cardiac Surgery

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| **Immediate** | • Critical (>90%) left main stenosis for surgery  
              • Significant (>50%) left main stenosis, with NSTEMI  
              • Surgical grade multi-vessel Coronary Artery Disease with hypotension / recurrent chest pain on heparin / requiring IABP insertion  
              • Mechanical complication post myocardial infarction  
              • Aortic dissection involving proximal aorta for open heart surgery  
              • Post PCI complication requiring open heart surgery  
              • Penetrating cardiac trauma / chest injury with circulatory failure |
| **24 Hours** | • Significant (70–90%) left main, stable angina pectoris  
              • Myxoma and other intracardiac mass with embolic and obstructive risk |
| **48 Hours** | • Prosthetic valve endocarditis  
              • Sternal infection  
              • Severe 3 vessel disease requiring in-patient revascularisation, consult surgical team |
| **72 Hours** | • Readmission of patient awaiting cardiac surgery to regional hospital |