Urgent Pathology Tests Guidance For Primary Care

This list is not exhaustive, and all we encourage clinical professionals to order samples where you believe they are clinically justified for the safe clinical management of your patients. This is intended as a guide to assist clinical staff in making an appropriate risk assessment of the clinical scenario.

	URGENT	ROUTINE
Renal profile	• diuretic adjustment in heart failure • clinical concern re hyper or hypo kalaemia • possible hyponatraemia e.g. polydipsia, polyuria • Acute kidney injury	• Post introduction of ACE or ARB – if clinically appropriate delay medication introduction, so renal profile at 2 weeks can also be delayed • Part of Long Term Condition (LTC) review – T2DM, CVD, CKD, etc
Liver profile	• Acute jaundice • Possible liver failure e.g. ascites • Cholestasis of pregnancy • Acute alcohol toxicity	• Part of LTC review • Post introduction of statin – consider delaying start of medication so liver profile at 6 weeks can also be delayed • Monitoring of long term liver conditions
Full Blood Count	• High risk anaemia e.g. severe menorrhagia, severe haemorrhoids, melaena • Possible haematological malignancy • Acute sepsis • Possible Immune Thrombocytopenic Purpura (ITP)	• To exclude anaemia in lower risk clinical scenarios • Monitoring/follow up of platelet count over 100
Urate	• Make a clinical diagnosis of acute gout and treat accordingly	• Monitoring of effectiveness of allopurinol
Ferritin, Iron studies	• If MCV reduced, treat as iron deficiency, consider FIT	• Diagnosis of iron deficiency
B12, Folate	• Symptomatic patient (neurological), with possible severe B12 deficiency	• Excluding deficiency in absence of severe symptoms
INR/ Coagulation screen	• For patients on warfarin with symptoms or recent dose change	• For patients with bruising, low risk bleeding
D-dimer	• D-dimer, for exclusion of VTE but consider whether better done in A&E if patient is symptomatic	

	URGENT	ROUTINE
CRP and ESR	• ESR - If possible diagnosis of temporal arteritis	• For diagnosis of inflammatory conditions
Vitamin D	• Confirmation of rickets in child, where high clinical suspicion	• Routine monitoring of patients at risk of nutritional deficiency e.g. parenteral feeding, post bariatric surgery
Bone profile	• Acute hypercalcaemia or hypocalcaemia	• Routine monitoring of hyperparathyroidism, or CKD stage 4 or 5
Thyroid profile	• Acute thyrotoxicosis/thyroid storm	• Routine monitoring of hyper or hypothyroidism
HbA1C	• N/A	• Routine monitoring of T2DM or NDH
Allergy testing	• N/A	• Diagnosis of possible Ige mediated allergies
Infertility testing	• N/A	• Diagnosis of primary/secondary infertility issues • Baseline tests prior to referral
DMARDS monitoring	• N/A	• Consider delaying tests if patient stable and has been stable for some time
FIT	• If patient may need to be referred onto 2ww pathway	• Follow up FIT to previously borderline sample
CA-125	• If clinically indicated and this may help to decide if 2ww referral is indicated	
PSA	• For suspected cancer – for 2ww diagnosis	• Consider delaying routine PSA testing for monitoring post cancer treatment or previous borderline result
MSU	• Where sensitivities are clinically important e.g. treatment failure, children and male adults, high risk systemic infection/sepsis	• Treat according to symptoms if positive dipstix (cloudy urine, leucocytes, nitrites) • Consider delaying MSU for investigation of lower urinary tract symptoms (LUTS) i.e. where using MSU to exclude infection
Mycology		These samples can be delayed