METRO NORTH HOSPITAL AND HEALTH SERVICE

ORTHOPAEDIC DEPARTMENTS

Adult Referral Evaluation and Management Guidelines

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EVALUATION AND MANAGEMENT GUIDELINES

For Emergency Referrals: Phone on call Orthopaedic Registrar via:

Royal Brisbane & Women's Hospital switch - (07) 3646 8111

The Prince Charles Hospital switch - (07) 3139 4000

Redcliffe Hospital switch – (07) 3883 7777

And send patient to the Department of Emergency Medicine (DEM) at their nearest hospital.

Category 1

i. Appointment within thirty (30) days is desirable; AND

ii. Condition has the potential to require more complex or emergent care if assessment is delayed; AND

iii. Condition has the potential to have significant impact on quality of life if care is delayed beyond thirty (30) days.

Category 2

i. Appointment within ninety (90) days is desirable; AND

ii. Condition is unlikely to require more complex care if assessment is delayed; AND

iii. Condition has the potential to have some impact on quality of life if care is delayed beyond ninety (90) days.

Category 3

i. Appointment is not required within ninety (90) days; AND

ii. Condition is unlikely to deteriorate quickly; AND

iii. Condition is unlikely to require more complex care if assessment is delayed beyond 365 days.

The Orthopaedic Department provides a high standard of complex patient care. Our patient waiting times are available on the http://www.performance.health.qld.gov.au/hospitalperformance/ website.

All urgent cases must be discussed with the on call Orthopaedic Registrar. Contact through RBWH switch (07) 3646 8111, TPCH (07) 3139 4000 or Redcliffe (07) 3883 7777 to obtain appropriate prioritisation and treatment. Urgent cases accepted via phone must be accompanied with a written referral and a copy faxed immediately to the Central Patient Intake Unit: 1300 364 952.

Where possible all non-metropolitan patients referred must include travel, accommodation, and escort arrangements. An inpatient bed may not be possible or relevant once the patient has been assessed by the Orthopaedic Department.

Referrals containing insufficient information or that are illegible will be returned to the referral centre. This may result in delayed appointment/treatment for your patient.

ORTHOPAEDIC DEPARTMENT CLINIC LOCATIONS

Royal Brisbane and Women's Hospital (RBWH)

Level 7, Ned Hanlon Building

The Prince Charles Hospital (TPCH)

Specialist Clinics, Ground Floor

Redcliffe Hospital

Level 1, Specialist Outpatient Department, Main Building

IN-SCOPE FOR ORTHOPAEDIC OUTPATIENT SERVICES

Please note this is not an exhaustive list of all conditions for Orthopaedic outpatient services and does not exclude consideration for referral unless specifically stipulated in the out-of-scope section.

• Achilles tendon pathology and rupture • Basal thumb arthritis • Dupuytren's contracture (Orthopaedics) • Foot and ankle arthritis • Ganglia • Hand trauma • Heel pain • Hip pain • Knee pain (acute) • Knee pain (chronic)	• Lower limb trauma (see also acute knee pain above) • Pain / deformity in forefoot and hind foot • Painful / stiff wrist • Shoulder and elbow conditions • Spinal fracture – acute osteoporotic / pathological fracture not requiring admission for pain relief • Spine / neck / back pain • Stenosing tenosynovitis • Upper limb nerve compression • Upper limb trauma

OUT-OF-SCOPE FOR OUTPATIENT SERVICES

Not all services are funded in the Queensland public health system. The following are not routinely provided in a public Orthopaedic service.

• Aesthetic or cosmetic surgery

EMERGENCY

If any of the following are present or suspected arrange immediate transfer to the emergency department.

The list below includes common traumatic injuries that require referral to emergency and should not be referred for elective / fracture clinic categorisation.

- Acute cervical myelopathy
- Acute back or neck pain secondary to neoplastic disease or infection
- Spinal injuries
- Suspected open fracture
- Fracture requiring manipulation or operation
- Suspected acute bone or joint infection
- Acute high energy fracture with/without neurological abnormality
- Injury associated with vascular compromise
- Clavicle fracture
- Osteoporotic / pathological fracture new abnormal neurology

- Suspected infection or sudden pain in arthroplasty
  - If joint infection is suspected refer immediately to emergency or contact the orthopaedic registrar on call
  - **do not commence antibiotics unless delay to specialist review is likely**
- Joint dislocations
- Open injuries with possible tendon or joint involved
- Nail bed injuries or retained foreign body
- Knee extensor mechanism rupture
- Acute peripheral nerve injury
- Suspected acute compartment syndrome

Spine, Neck, Back Pain Emergency

NB: contact the Orthopaedic/Neurosurgery/Spine Registrar on-call for advice.

- High risk of irreversible deficit if not assessed urgently
- Spinal trauma
- Spinal infections
- Significant spinal nerve root compression or spinal cord compression with progressive neurological signs/symptoms e.g.
  - Spinal cord compression with severe or rapidly progressing neurological deficit
  - Cauda equina syndrome
    - Bilateral nerve pain (leg pain below knees)
    - Bladder / bowel dysfunction
    - Perineal anaesthesia
    - Progressive weakness
  - Bone infection

METRO NORTH CENTRAL PATIENT INTAKE (CPI) UNIT

https://www.health.qld.gov.au/metronorth/refer/

GENERAL REFERRAL INFORMATION

Patient's Demographic Details

- Full name (including aliases)
- Date of birth
- Residential and postal address
- Telephone contact number/s – home, mobile and alternative
- Medicare number (where eligible)
- Name of the parent or caregiver (if appropriate)
- Preferred language and interpreter requirements
- Identifies as Aboriginal and/or Torres Strait Islander

Relevant Clinical Information about the Condition

- Presenting symptoms (evolution and duration)
- Physical findings
- Details of previous treatment (including systemic and topical medications prescribed) including the course and outcome of the treatment
- Body mass index (BMI)
- Details of any associated medical conditions which may affect the condition or its treatment (e.g. diabetes), noting these must be stable and controlled prior to referral
- Current medications and dosages
- Drug allergies
- Alcohol, tobacco and other drugs use

Referring Practitioner Details

- Full name
- Full address
- Contact details – telephone, fax, email
- Provider number
- Date of referral
- Signature

Reason for Request

- To establish a diagnosis
- For treatment or intervention
- For advice and management
- For specialist to take over management
- Reassurance for GP/second opinion
- For a specified test/investigation the GP can't order, or the patient can't afford or access
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)
- Clinical judgement indicates a referral for specialist review is necessary

Clinical Modifiers

- Impact on employment
- Impact on education
- Impact on home
- Impact on activities of daily living
- Impact on ability to care for others
- Impact on personal frailty or safety
- Identifies as Aboriginal and/or Torres Strait Islander

Other Relevant Information

- Willingness to have surgery (where surgery is a likely intervention)
- Choice to be treated as a public or private patient
- Compensable status (e.g. DVA, Work Cover, Motor Vehicle Insurance, etc.)

ORTHOPAEDIC CONDITIONS

Achilles Tendon Pathology and Rupture

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency or fracture clinic if clinically indicated:
	  ○ acute achilles tendon rupture
	  ○ if delayed presentation of achilles tendon rupture (>3 weeks)

Category 2 (appointment within 90 days is desirable)	• A tender, nodular swelling
Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - rate of deterioration of the condition
- Aggravating and relieving factors
- Pain assessment – waking up at night, analgesic consumption
- Interference with activities of daily living and working ability
- Neurological deficit
- X-ray results – AP and lateral ankle/foot
- USS results (not required for achilles rupture if examination confirms)

Additional Referral Information (Useful for processing the referral)

- Management to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports

Other useful information for referring practitioners (Not an exhaustive list)

- Management
  - analgesia/NSAIDs as appropriate
  - physiotherapy/podiatry (where available)
  - heel cups/heel raise (where available)
  - abstention from activities that caused the symptoms
  - backslab or moon boot for acute or suspected achilles tendon rupture. Review in fracture clinic
  - chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Basal Thumb Arthritis

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Refer directly to emergency if clinically indicated e.g. suspected septic arthritis
Category 2 (appointment within 90 days is desirable)	• Associated with inflammatory arthropathy affecting other joints • Rapid deterioration in function
Category 3 (appointment within 365 days is desirable)	• Not responding to maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- X-ray results – AP and lateral hand and wrist – instruct patient to bring imaging films/results to clinic appointment

Additional Referral Information (Useful for processing the referral)

- Management to date

Other useful information for referring practitioners (Not an exhaustive list)

- Management
  - analgesia/NSAIDs as appropriate
  - consider intra-articular steroid injection
  - splint and activity modification
  - occupational therapy/physiotherapy
  - chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Dupuytren's Contracture (Orthopaedics)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Skin breakdown and/or infection secondary to severe contracture
Category 2 (appointment within 90 days is desirable)	• Fixed flexion deformity of 90º at MCPJ or 60º at PIPJ • Multiple joints or recurrence after surgery with functional impairment • Rapidly progressing disease
Category 3 (appointment within 365 days is desirable)	• MCP flexion contracture > 30º • PIP flexion contracture > 20º • Functional impairment

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Management to date (including non-surgical)
- Assessment report including ROM measurement
- Details of functional impairment
- History of anticoagulant therapy
- Smoking status

Other useful information for referring practitioners (Not an exhaustive list)

- It is strongly recommended that people stop smoking before surgery as it is associated with delayed skin healing. Please consider directing your patient to a smoking cessation program.
- PIP joint contractures are more serious than MCP joint contractures.
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Management

- analgesia/NSAIDs as appropriate
- splint and activity modification
- occupational therapy/physiotherapy
- joint ROM exercises

- Most tertiary hand surgery units will soon be offering outpatient based non-surgical treatments for Dupuytren's. Referral to these clinics may be fast tracked.

Foot and Ankle Arthritis

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Refer directly to emergency if clinically indicated e.g. suspected septic arthritis • Skin ulceration secondary to deformity or pressure
Category 2 (appointment within 90 days is desirable)	• Presence of avascular necrosis • Associated with diabetic peripheral neuropathy
Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain persists despite maximal management, such as physiotherapy or managed weight loss

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - rate of deterioration of the condition
- Pain assessment – waking up at night, analgesic consumption, aggravating and relieving factors
- Interference with activities of daily living and working ability
- Nerve irritation signs (Tinel's foot sign or hyperaesthesia)
- Neurological deficit
- X-ray results – AP and lateral ankle/foot including weight bearing/standing views

Additional Referral Information (Useful for processing the referral)

- Management to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- consider steroid injection as appropriate
- physiotherapy
- podiatry
- mobility aid and activity modifications
- footwear advice/walking aids (where available)
- therapeutic massage
- obesity is associated with an increase in complications associated with surgery – consider dietitian & weight reduction monitoring if BMI is a concern
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Ganglia

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• If concerned that lump may be malignant or infective
Category 2 (appointment within 90 days is desirable)	• No category 2 criteria

Category 3
(appointment within 365 days is desirable)
	• Symptomatic or enlarging ganglion of the wrist/hand not suitable for primary health management that is any of the following:
	  ○ symptomatic
	  ○ causing concern
	  ○ enlarging

Essential Referral Information (Referral may be rejected without this)

- General referral information
- X-ray results (region involved) – instruct patient to bring imaging films/results to clinic appointment

Additional Referral Information (Useful for processing the referral)

- Management to date
- USS results (for clarification of presence of cyst)

Other useful information for referring practitioners (Not an exhaustive list)

Management

- consider aspiration (18g needle)
- consider steroid injection (as appropriate)
- do not aspirate volar ganglion
- consider repeating if aspiration is ≥ 2 years
- http://bestpractice.bmj.com/best-practice/monograph/984/treatment/step-by-step.html
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Hand Trauma

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Refer to emergency if clinically indicated, e.g. acute ligament and tendon rupture • Undisplaced fracture • Fractures that have been reduced satisfactorily • Delayed presentation nerve or tendon injury • Delayed presentation joint dislocation
Category 2 (appointment within 90 days is desirable)	• Delayed fracture union or non-union • Mal-union affecting function
Category 3 (appointment within 365 days is desirable)	• Mal-union – normal function

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - date
  - time
  - mechanism
  - severity or evolution of injury
- Previous orthopaedic conditions and operations
- Other joint involvement
- Management to date (immobiliser, splint or cast etc.)
- X-ray results – instruct patient to bring imaging films/results to clinic appointment.

Other useful information for referring practitioners (Not an exhaustive list)

- Timing of first review appointments at orthopaedic outpatient's/fracture clinic
  - If there is documentation indicating adequate alignment and satisfactory initial treatment of fracture – to be seen within 14 days of referral
  - All other fracture cases, delayed presentation of tendon and nerve injuries – to be seen within 7 days of referral
- Do not delay referral for open or unstable fractures – refer to emergency or contact the orthopaedic registrar on-call
- Please refer early as treatment may change with a delayed referral
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Management

- assess and document neurovascular status
- check X-ray post manipulation (if applicable)
- immobiliser, splint or cast as appropriate

Heel Pain

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Suspected malignancy
	• Refer directly to fracture clinic, where available, if associated with any of the following:
	  ○ trauma
	  ○ infection
	  ○ ulceration
	  ○ suspected fracture

Category 2 (appointment within 90 days is desirable)	• If associated with diabetic peripheral neuropathy
Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - rate of deterioration of the condition
- Aggravating and relieving factors
- Pain assessment – waking up at night, analgesic consumption
- Interference with activities of daily living and working ability
- Nerve irritation signs (Tinel's foot sign or hyperaesthesia)
- Neurological deficit
- X-ray results – AP and lateral ankle/foot including weight bearing/standing views

Additional Referral Information (Useful for processing the referral)

- Management to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports (if available)

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate

NB Ibuprofen is effective in the 'reactive' (acute/acute-on-chronic) stage of tendinopathy

- Steroid injections for plantar fasciitis under the trigger point
- Physiotherapy/podiatry (where available)
- Footwear advice/walking aids e.g. modification footwear/heel cups/heel raise (where available)
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Hip Pain

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Refer directly to emergency if clinically indicated e.g. suspected septic arthritis • Past history or suspicion of malignancy and/or lesion on X-ray • Radiological evidence of avascular necrosis of hip in a patient <60 years • History of trauma / falls

Category 2
(appointment within 90 days is desirable)
	• Severe symptoms impairing quality of life, based on:
	  ○ pain and/or disability
	  ○ sleep disturbance
	  ○ relating to mobility/independence
	  ○ inability to undertake normal activities
	  ○ reduced functional capacity or psychiatric illness
	  ○ unresponsive to therapy over ≥ 2 months
	• Gradual onset pain in previously well-functioning arthroplasty
	• Radiological evidence of avascular necrosis of hip > 60 years of age

Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms, length and severity of symptoms / degree of disability/ability/mobility
  - recurrent infections
- Previous joint surgery (THR/TKR)
- Height, weight and BMI
- Examination of ROM and fixed deformity
- Is the condition stable or how quickly has it deteriorated?
- Details of functional impairment. Level of ability to do daily activities/walking distance/ability to put on shoes
- X-ray results – AP pelvis AP affected hip showing proximal 2/3 femur and lateral affected hip. Instruct patient to bring imaging films/results to clinic appointment
- FBC ESR CRP results

Additional Referral Information (Useful for processing the referral)

- MRI results if avascular necrosis is suspected (where available and not cause significant delay)
- Management to date
- Has non-operative management been completed?
- Hip and knee questionnaire (patient to complete)

Other useful information for referring practitioners (Not an exhaustive list)

- Diagnosis and management of hip and knee osteoarthritis RACGP, Clinical guidelines, Diagnosis and management of hip and knee osteoarthritis

Management

- analgesia/NSAIDs as appropriate
- physiotherapy/hydrotherapy (where available)
- mobility aid and activity modification (i.e. use of a walking aid contralateral hand)
- remain active as pain allows (get moving program/home exercise program)
- home modification and use of adult day care
- better health self-management program
- obesity is associated with an increase in complications associated with surgery – consider dietitian & weight reduction monitoring if BMI is a concern
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery

Knee Pain (acute)

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency if clinically indicated:
	  ○ suspected septic arthritis
	  ○ acute extensor mechanism rupture
	  ○ X-ray demonstrates fracture
	• Locked knee
	• Significant internal or ligamentous derangement

Category 2
(appointment within 90 days is desirable)
	• Identified:
	  ○ post traumatic instability
	  ○ meniscal injuries (without degeneration)
	  ○ effusion
	• Unstable patella
	• Avascular necrosis of the tibial plateau

Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - date
  - recurrence of injury and mechanism
  - severity or evolution of injury
- Pain or other symptoms including haemarthrosis / effusion, locking, instability
- True locking (versus intermittent stiffness)
- X-ray results – knee weight bearing AP, lateral and skyline

Additional Referral Information (Useful for processing the referral)

- Clinical ligament and meniscus test results, if completed
- MRI results for suspected locked knee or significant internal or ligamentous derangement (where available and does not cause significant delay to patient accessing outpatient service)
- Hip and knee questionnaire (patient to complete)

Other useful information for referring practitioners (Not an exhaustive list)

- Timing of first review appointments at orthopaedic outpatients:
  - if there is documentation indicating adequate alignment and satisfactory initial treatment of fracture – to be seen within 14 days of referral
  - all other fracture cases, delayed presentation of tendon and nerve injuries - to be seen within 7 days of referral
- Do not commence antibiotics unless delay to specialist review is likely - discuss with orthopaedic registrar on-call.

- Weight bearing X-rays are preferred to an MRI as MRI's are expensive for the patients and do not add any value to diagnosis or treatment options
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Management

- X-ray to rule out fracture
- analgesia/anti-inflammatories/ NSAIDs as appropriate
- physiotherapy/hydrotherapy (where available)
- mobility aid and activity modification
- remain active as pain allows (get moving program/home exercise program)
- home modification and use of adult day care
- better health self-management program
- obesity is associated with an increase in complications associated with surgery – consider dietitian & weight reduction monitoring if BMI is a concern

Knee Pain (chronic)

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency if:
	  ○ evidence of acute inflammation for example:
	  ▪ haemarthrosis
	  ▪ tense effusion
	• Suspected malignancy

Category 2 (appointment within 90 days is desirable)	• Symptoms rapidly deteriorating and causing severe disability • Pain in previously well-functioning arthroplasty
Category 3 (appointment within 365 days is desirable)	• Some functional impairment and/or pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - date
  - recurrence of injury and mechanism
  - severity of evolution of injury
  - recurring infections
- Pain and other symptoms including effusion, locking, instability
- Previous joint surgery
- True locking (vs intermittent stiffness)
- Results of clinical ligament and meniscus tests if completed
- Height, weight and BMI
- X-ray results – knee, weight bearing AP, lateral and skyline of both knees
- Investigations for inflammatory arthropathy

Additional Referral Information (Useful for processing the referral)

- Management to date
- Has non-operative management been completed?
- Hip and knee questionnaire (patient to complete)

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- avoid steroid injection
- physiotherapy/hydrotherapy (where available)
- mobility aid and activity modification/gait aid
- remain active as pain allows (get moving program/home exercise program)
- home modification and use of adult day care
- better health self-management program
- obesity is associated with an increase in complications associated with surgery – consider dietitian & weight reduction monitoring if BMI is a concern
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Lower Limb Trauma (see also acute knee pain above)

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Undisplaced fracture • Fracture that has been reduced satisfactorily • Delayed presentation nerve or tendon injury • Delayed presentation joint dislocation
Category 2 (appointment within 90 days is desirable)	• Fracture delayed or non-union • Mal-union affecting function
Category 3 (appointment within 365 days is desirable)	• Mal-union not affecting function

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - date
  - time
  - mechanism
  - severity or evolution of injury
- Management to date (immobiliser, splint, cast etc.)
- X-ray results – instruct patient to bring imaging films/results to clinic appointment

Other useful information for referring practitioners (Not an exhaustive list)

- Timing of first review appointments at orthopaedic outpatient's/fracture clinic
  - if there is documentation indicating adequate alignment and satisfactory initial treatment of fracture – to be seen within 14 days of referral
  - all other fracture cases, delayed presentation of tendon and nerve injuries - to be seen within 7 days of referral
- Do not delay referral for open, unstable fractures — refer to emergency or contact the orthopaedic registrar on-call.
- Please refer early as treatment may change with a delayed referral
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Management

- assess and document neurovascular status
- check X-ray post manipulation (if applicable)
- immobiliser, splint or cast as appropriate

Pain / Deformity in Forefoot and Hind Foot

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Suspected malignancy
	• Refer directly to fracture clinic if associated with any of the following:
	  ○ trauma
	  ○ infection
	  ○ ulceration/threatened ulceration
	  ○ suspected fracture

Category 2 (appointment within 90 days is desirable)	• If associated with diabetic neuropathy
Category 3 (appointment within 365 days is desirable)	• Functional impairment and pain persists despite maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - rate of deterioration of the condition
- Aggravating and relieving factors
- Pain assessment – waking up at night, analgesic consumption
- Interference with activities of daily living and working ability
- Neurological deficit
- Nerve irritation signs
- X-ray results – AP and lateral ankle/foot including weight bearing/standing views

Additional Referral Information (Useful for processing the referral)

- Management to date (including insoles and physiotherapy)
- High risk foot clinic or podiatrist reports

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- check tibialis posterior
- footwear advice/walking aids e.g. modification footwear/arch supports
- physiotherapy/podiatry (where available)
- orthoses (where available)
- consider USS - guided steroid injection for Morton's neuroma / intermetatarsal bursa as appropriate
- obesity is associated with an increase in complications associated with surgery – consider dietitian & weight reduction monitoring if BMI is a concern
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Painful / Stiff Wrist

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency if clinically indicated e.g. suspected septic arthritis
	• History of trauma
	  ○ Undisplaced fracture
	  ○ Fracture that have been reduced satisfactorily
	  ○ Delayed presentation nerve or tendon injury
	  ○ Delayed presentation joint dislocation

Category 2 (appointment within 90 days is desirable)	• Rapid deterioration in function • History of inflammatory disease – consider referral to rheumatology
Category 3 (appointment within 365 days is desirable)	• Abnormal X-ray or painful / stiff wrist not responding to maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of fall or trauma/mechanism of injury
- X-ray results – AP and lateral wrist (consider scaphoid views) – instruct patient to bring imaging films/results to clinic appointment

Additional Referral Information (Useful for processing the referral)

- Management to date
- Results for investigations for inflammatory arthropathy
- FBC ESR & CRP results if inflammation is suspected

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- trial of wrist splint and activity modification
- occupational therapy/physiotherapy
- consider infection, inflammatory and crystal arthropathies as well as arthritis
- history of trauma / falls
  - mechanism of injury
  - assess and document neurovascular status
  - check X-ray post manipulation (if applicable)
  - immobilise fractured limb in a sling, shoulder immobiliser or cast as appropriate
- history of inflammatory disease – consider referral to rheumatology
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Shoulder & Elbow Conditions

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency if:
	  ○ Clinically indicated e.g. suspected septic arthritis
	  ○ Evidence of acute inflammation, e.g:
	  ▪ haemarthrosis
	  ▪ tense effusion
	• Suspicion of malignancy

Category 2 (appointment within 90 days is desirable)	• First episode of shoulder dislocation in a patient <25 years old • Recurrent dislocated shoulder/shoulder instability • Instability associated with structural pathology in a patient <40 years old e.g. SLAP lesion, large Bankart lesion • History of trauma suggests acute event / tear (rather than degenerative) rotator cuff tear • Shoulder adhesive capsulitis (frozen shoulder)
Category 3 (appointment within 365 days is desirable)	• Functional impairment and/or pain of shoulder/elbow and failed maximal medical management • AC joint conditions • Chronic weakness and degenerative rotator cuff • Rotator cuff tendinopathy ○ sub-acromial impingement • Pain/stiffness in elbow not responding to maximal medical management • Elbow tendonitis

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - duration
  - recurrence of injury and mechanism
  - severity or evolution of injury
- Arm ROM with any neurological examination/signs
- X-ray results – AP and lateral shoulder/elbow
- USS results if suspected rotator cuff pathology

Additional Referral Information (Useful for processing the referral)

- Management to date
- Physiotherapy assessment report
- According to clinical suspicion
  - CT / MRI results
  - protein electrophoresis
  - immunoglobulins
  - calcium and phosphate

- rheumatoid serology
- If inflammation / infection suspected
  - FBC ESR CRP results

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- physiotherapy
- activity modification
- advice to avoid dislocation (recurrent)
- shoulder rehabilitation program
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.
- Consider corticosteroid injection for:
  - rotator cuff tendinopathy
  - AC joint pain
  - frozen shoulder where pain predominates (early stages)
  - shoulder OA if patient is unwilling/unsuitable for surgical management
  - sub-acromial impingement

Spinal Fracture - acute osteoporotic / pathological fracture not requiring admission for pain relief

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Refer directly to emergency if: ○ osteoporotic / pathological fracture suspected infection (refer to list of referral to emergency) • Osteoporotic / pathological fracture suspected malignancy
Category 2 (appointment within 90 days is desirable)	• No category 2 criteria

Category 3
(appointment within 365 days is desirable)
	• Osteoporotic / insufficiency fracture with ongoing pain with the absence of **Red Flags**
	• **Red Flags**
	  ○ age (at onset) < 16 or > 55
	  ○ motor deficit e.g. foot weakness
	  ○ recent significant trauma
	  ○ unexplained weight loss
	  ○ history of cancer
	  ○ history of IV drug use
	  ○ prolonged use of corticosteroids
	  ○ severe night pain
	  ○ infection/fever

Essential Referral Information (Referral may be rejected without this)

- General referral information
- History of:
  - symptoms
  - date
  - time
  - mechanism
  - severity of evolution of injury
- Management to date (immobiliser, splint or cast etc.)
- X-ray results – instruct patient to bring imaging films/results to clinic appointment

Other useful information for referring practitioners (Not an exhaustive list)

- Timing of first review appointments at orthopaedic outpatient's/fracture clinic
  - if there is documentation indicating adequate alignment and satisfactory initial treatment of fracture – to be seen within 14 days of referral
  - all other fracture cases, delayed presentation of tendon and nerve injuries - to be seen within 7 days of referral
- Do not delay referral for open, unstable fractures — refer to emergency or contact the orthopaedic registrar on-call.
- Please refer early as treatment may change with a delayed referral

- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Sheffield back pain Red Flags:

- age (at onset) < 16 or > 55
- motor deficit e.g. foot weakness
- recent significant trauma
- unexplained weight loss
- history of cancer
- history of IV drug use
- prolonged use of corticosteroids
- severe night pain
- infection/fever

Management

- pain management
- physiotherapy
- Orthopaedic Physiotherapy Screening Clinic pathways (OPSC)
- management of osteoporosis
- treatment of underlying cause

Spine / Neck / Back Pain

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Risk irreversible deficit if not seen within 1-4 weeks • Significant spinal nerve root compression or spinal cord compression with slower evolving neurological signs/symptoms • Severe pain with significant functional impairment • Suspected spinal tumours (benign or malignant) • Moderate to severe sciatica with recent reflex and muscle power deficit e.g. foot weakness • Moderate to severe neck and arm pain with recent reflex and muscle power deficit
Category 2 (appointment within 90 days is desirable)	• Less severe and more long-standing pain with significant functional impairment • Acute cervical & lumbar disc prolapse with stable neurological signs/symptoms • Severe degenerative spinal disorders with limitation of activity of daily living (ADL) • Acute cervical or lumbar disc prolapse with mod-severe limb pain but minimal neurological deficit • Documented severe lumbar canal stenosis with significant neurogenic claudication/limitation of walking distance • Acute Pars defect in young adult • Anterolisthesis/spondylolisthesis with lower limb neurology and/or instability on flexion/extension X-rays
Category 3 (appointment within 365 days is desirable)	• Mechanical lower back pain without lower limb pain • Stable mild neurological symptoms/signs which is unlikely to progress if left untreated or in whom a good surgical outcome is uncertain • Pain that is manageable or reasonably controlled with analgesia • Chronic LBP/neck pain (without leg or arm pain) • Most cases of chronic cervical and lumbar disc prolapse and degenerative spinal disorders with no to stable mild neurological deficit • Long-standing spondylolisthesis with stable neurology

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Presence and duration of neurological signs and symptoms
- Weight loss, loss of appetite and lethargy
- Fever and sweats
- Management to date (including previous spinal surgery)
- History of malignant disease / IV drug use
- Recurrence of injury and mechanism
- Severity or evolution of injury
- General medical condition

- Continence difficulties/sexual function
- Work status, functional impairment/time of work
- X-ray results – AP & lateral spine including standing views and CT/MRI results (if available)
- ELFT FBC ESR CRP results rheumatoid serology (in specific cases)

Additional Referral Information (Useful for processing the referral)

- Plain lateral standing X-rays in flexion and extension for lumbar spondylolisthesis
- Spinal referral questionnaire
- Calcium and phosphate, electrophoresis, immunoglobins, PSA, rheumatoid serology (in specific cases)
- Physiotherapist report

Other useful information for referring practitioners (Not an exhaustive list)

NB: Back pain with red flags – if clinical circumstances indicate the patient requires immediate treatment, refer to emergency.

Sheffield back pain Red Flags:

- age (at onset) < 16 or > 55
- motor deficit e.g. foot weakness
- recent significant trauma
- unexplained weight loss
- history of cancer
- history of IV drug use
- prolonged use of corticosteroids
- severe night pain
- infection/fever

Many Category 2 and 3 patients referred for a surgical opinion do not require surgery or a surgical opinion. Evidence demonstrates that non-surgical management is as effective for a number of spinal conditions.

Where services are available, category 2 and 3 patients will initially be assessed / reassessed and case managed by an expert musculoskeletal physiotherapist. Outcomes from this or subsequent review may include discharge, provision of appropriate non-surgical management plans, discussion or appointment with a spinal surgeon.

Management

- analgesia/anti-inflammatories/ NSAIDs as appropriate
- physiotherapy/hydrotherapy/ back education group (if available) – minimum 6 week program
- strengthening exercises and aerobic fitness training
- activity modification (remain comfortably active)
- Heat/gentle massage/acupuncture
- Monitor neurological function
- Complete 'Keele STarT Back' screening tool to identify risk of developing chronic spinal pain. Low to medium risk suggests ongoing management in primary care is appropriate.

Stenosing Tenosynovitis

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• New onset of permanently fixed trigger finger
Category 2 (appointment within 90 days is desirable)	• Chronic permanently fixed trigger finger

Category 3
(appointment within 365 days is desirable)
	• Stenosing tenosynovitis suggested by 1 or more of the following symptoms:
	  ○ tingling
	  ○ numbness
	  ○ stiffness
	  ○ locking
	  ○ tenderness
	  ○ painful clicking >6 months
	• Failed maximal management including one steroid injection and splints
	• Intermittent trigger finger / stenosing tenosynovitis persists

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Management to date
- Describe chronicity
- Determine if there is normal passive ROM in the MP, PIP and DIP joints
- USS results

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs (as appropriate)
- consider steroid injection (as appropriate)
- occupational therapy / physiotherapy to maintain mobility / prevent stiffness and contracture / maintain extension / prevent / control pain / strengthening
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Upper Limb Nerve Compression

Minimum Referral Criteria	

Category 1
(appointment within 30 days is desirable)
	• Refer directly to emergency if:
	  ○ upper limb radiculopathy in the presence of suspected cervical spine infection
	  ○ upper limb nerve compression in association with trauma or acute event
	• Upper limb radiculopathy in the presence of suspected cervical spine malignancy

Category 2 (appointment within 90 days is desirable)	• Continuous pain and / or muscle weakness in distribution of peripheral upper limb nerve • Recurrent symptoms after surgical decompression • Rapid progressive deterioration
Category 3 (appointment within 365 days is desirable)	• Intermittent symptoms without weakness or wasting in distribution of peripheral upper limb nerve • Carpal tunnel syndrome refer after 6 months of maximal management • Ulnar entrapment neuropathy when no response to ≥ 6 months or maximal management

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Management to date

Additional Referral Information (Useful for processing the referral)

- X-ray results – AP and lateral (of region) if available
- Nerve conduction studies (where available and does not cause significant delay to patient accessing outpatient service)

Other useful information for referring practitioners (Not an exhaustive list)

Management

- analgesia/NSAIDs as appropriate
- consider steroid injection (e.g. carpal tunnel syndrome) as appropriate
- night splint (e.g. carpal tunnel syndrome)
- occupational therapy / physiotherapy - for splinting, joint ROM exercises to maintain mobility, neural gliding exercises
- chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Upper Limb Trauma

Minimum Referral Criteria	
Category 1 (appointment within 30 days is desirable)	• Undisplaced fracture • Fracture that has been reduced satisfactorily • Delayed presentation nerve or tendon injury • Delayed presentation joint dislocation
Category 2 (appointment within 90 days is desirable)	• Fracture delayed or non-union • Mal-union affecting function
Category 3 (appointment within 365 days is desirable)	• Mal-union not affecting function

Essential Referral Information (Referral may be rejected without this)

- General referral information
- Previous orthopaedic conditions and operations
- History of:
    - symptoms
    - date
    - time
    - mechanism
    - severity of evolution of injury
- Treatment to date (immobiliser, splint or cast etc.)
- Other joint involvement
- X-ray results – scaphoid views only if out of plaster. Instruct patient to bring imaging films/results to clinic appointment

Other useful information for referring practitioners (Not an exhaustive list)

- Timing of first review appointments at orthopaedic outpatient's/fracture clinic
    - if there is documentation indicating adequate alignment and satisfactory initial treatment of fracture – to be seen within 14 days of referral
    - all other fracture cases, delayed presentation of tendon and nerve injuries - to be seen within 7 days of referral
- Do not delay referral for open, unstable fractures — refer to emergency or contact the orthopaedic registrar on-call.
- Please refer early as treatment may change with a delayed referral
- Chronic disease requires to be optimised prior to referral or the patients may not proceed to surgery.

Management

- assess and document neurovascular status
- check X-ray post manipulation (if applicable)
- immobilise fractured limb in a sling, shoulder immobiliser or cast as appropriate.