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REFERRAL GUIDELINES: ORTHOPAEDIC SURGERY

Essential Referral Content

Demographic	Clinical
• Date of birth	• Reason for referral
• Contact details (including mobile phone)	• Duration of symptoms
• Referring GP details	• Relevant pathology & imaging reports
• Interpreter requirements	• Past medical history
• Medicare number	• Current medications

The Alfred Outpatient Referral Form is available to print and fax to the Outpatient Department on 9076 6938

Please provide MRI results where appropriate to expedite patient management.

Please note: Medicare rebates apply for MRIs requested by a GP for patients over 16 years of age for:

- MRI cervical spine for radiculopathy or trauma;
- MRI knee for acute knee trauma with possible meniscal tear or anterior cruciate tear.

For further information click here

Exclusion Criteria

The following conditions are not routinely seen at the Alfred:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen at The Alfred
- Bone and soft tissue tumours should be referred urgently to St Vincent's Hospital
- Hip arthroscopy is not currently offered at The Alfred

Please note: All referrals for hip and knee osteoarthritis attend the Osteoarthritis Hip and Knee Service (OAHKS), which is staffed by physiotherapists. Referrals may also be triaged and allocated to the Physiotherapy Screening Clinic (direct referrals are not accepted.)

Please note: The times to assessment may vary depending on size and staffing of the hospital department.

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Orthopaedic Registrar on call on 9076 2000.

The Alfred gratefully acknowledges the assistance of the Canterbury and District Health Board in New Zealand in developing these guidelines.
They are intended as a guide only and have been developed in conjunction with the Heads of Unit of The Alfred.

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REFERRAL PRIORITY: ORTHOPAEDIC SURGERY

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

IMMEDIATE Direct to the Emergency & Trauma Centre	URGENT Appointment timeframe within 30 days	ROUTINE Appointment timeframe greater than 30 days
• Cauda equina • Foot drop • Cervical myelopathy • Septic arthritis • Bone or joint infection • Suspected infection or sudden pain in arthroplasty • Back or neck pain secondary to neoplastic disease or infection	• Bone and soft tissue tumours should be referred to St Vincent's Hospital • Sympathetic dystrophia (refer to Pain Clinic at Caulfield Hospital) • Fractures and ligamentous injuries • Avascular necrosis • Carpal tunnel syndrome with muscle wasting or associated with pregnancy	• Chronic back/neck pain • Symptomatic bunions/foot conditions • Minor orthopaedic problems of the hands, ankles and feet including ganglions, also shoulder pain and non-specific back pain
Phone the Orthopaedic Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.	Urgent cases must be discussed with the Orthopaedic Registrar on call to obtain appropriate prioritisation and a referral faxed to 9076 6938.	Fax referral to 9076 6938

All referrals for hip and knee osteoarthritis attend the Osteoarthritis Hip and Knee Service (OAHKS), which is staffed by physiotherapists.
Referrals may also be triaged and allocated to the Physiotherapy Screening Clinic (direct referrals are not accepted.)

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REFERRAL PRIORITY: ORTHOPAEDIC SURGERY

Patients presenting to the Emergency and Trauma Centre with acute injuries and fractures are referred either to their GP or community physiotherapist for follow up management, to the Physiotherapy ED review clinic, or to Fracture clinic, as described in the table below. If you wish to discuss an acute referral, please contact the Orthopaedic registrar on call on 9076 2000.

GP or community physiotherapist

- Isolated undisplaced fractures
- Grade 1 acromioclavicular joint sprain
- Elbow radial head type 1 fractures (review at 2 weeks)
- Wrist joint sprains managed in a volar splint
- Closed, undisplaced, rotationally stable finger fractures
- Undisplaced patella fractures
- Ankle soft tissue injury or ligamentous grade 1 sprain able to weight bear
- Weber A undisplaced ankle fracture (review at 2 weeks)
- Undisplaced foot fracture with negative CT, Camboot and able to weight bear (except talus fracture)
- Closed, undisplaced, rotationally stable toe fractures

Physiotherapy ED review clinic

- Significant soft tissue injuries, specific undisplaced fractures , specific dislocation, where further orthopaedic liaison and follow up may or may not be required
- Soft tissue shoulder injury (rotator cuff) ligamentous (AC grade 2) and dislocations (shoulder not AC), calcific tendinitis
- Recurrent shoulder dislocations for workup for orthopaedic consultation
- Elbow radial head type 1 fractures (review at one week for mobilisation)
- Soft tissue and ligamentous knee injuries; meniscal and patella dislocations and /or unable to weight bear
- Ligamentous Grade 2&3 ankle injuries and unable to weight bear at 1 week.
- Soft tissue foot injury and unable to weight bear

Fracture clinic

- Open, complex, comminuted, displaced fractures
- Shoulder AC grade 3+ (may require admission)
- Distal clavicle and all humerus fractures
- Acute traumatic rotator cuff injuries
- SCJ dislocation
- Forearm fractures (may require admission)
- All elbow fractures and dislocations except radial head type 1
- Bicep rupture
- Displaced or angulated wrist or carpal (scaphoid) fracture
- Displaced thumb, metacarpal and finger fractures and dislocations are referred to Plastic Surgery
- #NOF, femur, hip and pelvis fracture
- Quadriceps or patella tendon rupture (may require admission)
- Knee dislocation (may require admission)
- All proximal tibial/fibular fractures
- Displaced patella fractures
- Unstable ligamentous Grade 3 ankle injuries (may require admission)
- Ankle Weber B and C (may require admission)
- Achilles rupture (may require admission)
- 2nd metatarsal base toe fracture with other injuries, displaced Jones fracture or professional sports player
- Calcaneum and talus fractures (may require admission)
- Displaced toe fractures

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Referral Guideline Contents

Shoulder:

- Rotator cuff tendinitis
- Pain/stiffness in the shoulder including frozen shoulder
- AC joint problems
- Recurrent dislocation of the shoulder
- Shoulder instability

Elbow:

- Tennis elbow
- Golfer's elbow
- Elbow pain / stiffness / locking

Wrist & Hand:

- Carpal tunnel
- Stenosing tenovaginitis (trigger finger, De Quervain's)
- Basal thumb arthritis
- Ganglia
- Painful / stiff wrists

Back:

- Mechanical low back pain without leg pain
- Back pain and sciatica without neurology
- Spinal stenosis with limitation of walking distance
- Back pain and sciatica with neurological deficit
- Back pain secondary to neoplastic disease or infection
- Back pain with neurological bladder involvement (cauda equina syndrome)

Neck:

- Neck pain without arm pain
- Neck pain with arm pain, without neurology
- Neck pain and radicular arm pain with neurological deficit
- Neck pain secondary to neoplastic disease or infection
- Neck pain with myelopathy

Hip and Knee:

- Osteoarthritis
- Inflammatory Arthritis
- Post Traumatic Arthritis
- Avascular Necrosis
- Previous total hip & knee replacement (THR / TKR) infection, loosening or wear

Ankles & Feet:

- Arthritis
- Pain & Deformity in Forefoot (Including Bunions)
- Pain & Instability in Hind Foot
- Achilles Tendon Pathology
- Heel Pain

Miscellaneous:

- Nerve entrapment syndromes
  - Carpal tunnel
  - Ulnar neuritis
  - Tarsal tunnel
- Bone and/or joint infection
- Bone and soft tissue tumours
- Bursitis
  - Pre-patellar bursitis
  - Trochanteric bursitis
  - Olecranon bursitis
- Apophysitis (eg Osgood-Schlatter's)
- Symptomatic prostheses (including joint replacements), rods, plates, screws or pins

Fractures

Soft tissue injuries

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Shoulder:

ROTATOR CUFF TENDONITIS
PAIN/STIFFNESS IN THE SHOULDER INCLUDING FROZEN SHOULDER
AC JOINT PROBLEMS

Evaluation	Management	Referral Guidelines
• Standard history and examination including neurological examination • X-rays (AP & lat shoulder) • U/S scan • Consider FBE, ESR & CRP	• Anti inflammatories • Physiotherapy • Consider Cortisone injection	• Refer if patient fails to respond to treatment. • Evidence of weakness and a history of significant trauma suggestive of an acute (rather then degenerative) rotator cuff tear is more urgent and should be seen promptly.

RECURRENT DISLOCATION OF SHOULDER
SHOULDER INSTABILITY

Evaluation	Management	Referral Guidelines
• Standard history and examination particularly neurological examination • X-rays (AP & lateral shoulder)	• Advice to avoid dislocation • Shoulder rehabilitation program (physiotherapy)	Refer if recurrent functional instability and/ or pain and has not responded to the rehabilitation program.

Elbow:

TENNIS / GOLFER'S ELBOW

Evaluation	Management	Referral Guidelines
Standard history and examination	• Bands • Anti inflammatories • Modify activity (eg patient with tennis elbow to use wrist in supination as much as possible) • Physiotherapy • Consider Cortisone injection	Refer if fails to respond to treatment.

ELBOW PAINFUL / STIFFNESS / LOCKING

Evaluation	Management	Referral Guidelines
• Standard history and examination • Consider FBE, ESR & CRP if inflammation suspected	• Anti inflammatories • Physiotherapy	Refer if not responding to treatment or loose bodies seen on XR.

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Wrist and Hand:

CARPAL TUNNEL SYNDROME

Evaluation	Management	Referral Guidelines
Nerve conduction studies can be performed at The Alfred; phone 9076 2058, Fax 9076 6075.	• Consider one steroid injection • Splintage	Refer as Urgent if muscle wasting or associated with pregnancy. May also be referred to Plastic Surgery, Neurosurgery or General Surgery Clinics.

STENOSING TENOSYNOVITIS (trigger finger and De Quervain's)

Evaluation	Management	Referral Guidelines
Standard history and examination	Consider injection with steroids	Refer if functional impairment or if unresponsive to treatment after injection.

BASAL THUMB ARTHRITIS

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-rays (AP & lateral):	• Anti inflammatories • Activity modification • Consider steroid injection • Splinting/Physiotherapy	Refer if fails to respond to treatment.

GANGLIA

Evaluation	Management	Referral Guidelines
Standard history and examination	Consider aspiration (18g needle) and multiple puncture	Refer if ganglia symptomatic - cosmesis alone is not a reason for referral.

PAINFUL / STIFF WRISTS

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP & lateral wrist): • FBE, ESR & CRP if inflammation suspected	• Anti inflammatories • Trial of wrist splint • Physiotherapy	Refer if X-ray abnormal or if does not respond to adequate conservative treatment.

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Back:

MECHANICAL LOW BACK PAIN WITHOUT LEG PAIN
BACK PAIN AND SCIATICA WITHOUT NEUROLOGY
SPINAL STENOSIS WITH LIMITATION OF WALKING DISTANCE

Evaluation	Management	Referral Guidelines
Standard history and examination including key points: • Duration of symptoms • Presence of neurological symptoms and signs • Functional impairment • Time off work • Weight loss, loss of appetite and lethargy • Fever and sweats • Treatment to date • Previous spinal surgery • Previous malignant disease • General medical condition and medication Investigations if symptoms persist: • X-ray (AP & lateral spine including standing views) • CT scan/MRI **NB: MRI is the preferred imaging modality for spinal conditions** • FBE, ESR, & CRP if inflammation is suspected • Biochemistry Consider according to clinical suspicion: • Calcium and phosphate • Protein electrophoresis • Immunoglobulins • PSA • Rheumatoid serology	• Physiotherapy • Activity modification • Analgesics and NSAIDs (see ACC guidelines booklet)	Refer if significant symptoms persisting >6/52.

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Back:

BACK PAIN AND SCIATICA WITH NEUROLOGICAL DEFICIT

Evaluation	Management	Referral Guidelines
Standard history and examination including key points: • Duration of symptoms • Presence of neurological symptoms and signs • Functional impairment • Time off work • Weight loss, loss of appetite and lethargy • Fever and sweats • Treatment to date • Previous spinal surgery • Previous malignant disease • General medical condition and medication Investigations if symptoms persist: • X-ray (AP & lateral spine including standing views) • CT scan/MRI **NB: MRI is the preferred imaging modality for spinal conditions** • FBE, ESR, & CRP if inflammation is suspected • Biochemistry Consider according to clinical suspicion: • Calcium and phosphate • Protein electrophoresis • Immunoglobulins • PSA • Rheumatoid serology		If cauda equina or foot drop – refer **IMMEDIATELY** – phone Orthopaedic Registrar on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre. Acute sciatica with radicular muscle power deficit, refer - Urgent. Acute sciatica with radicular sensory deficit only refer Urgent or Routine depending on severity.

BACK PAIN SECONDARY TO NEOPLASTIC DISEASE OR INFECTION

BACK PAIN WITH NEUROLOGICAL BLADDER INVOLVEMENT (CAUDA EQUINA SYNDROME)

Evaluation	Management	Referral Guidelines
		Refer **IMMEDIATELY** – phone Orthopaedic Registrar on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre.

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Neck:

NECK PAIN WITHOUT ARM PAIN

NECK PAIN WITH ARM PAIN WITHOUT NEUROLOGY

Evaluation	Management	Referral Guidelines
Standard history and examination including key points: • Duration of symptoms • Presence of neurological symptoms and signs • Functional impairment • Time off work • Weight loss, loss of appetite and lethargy • Fever and sweats • Treatment to date • Previous spinal surgery • Previous malignant disease • General medical condition and medication Investigations if symptoms persist: • X-ray (AP & lateral cervical spine) • CT scan/MRI **Please note:** Medicare now provides a rebate for MRI cervical spine for cervical radiculopathy or trauma in patients over 16 years of age when requested by a General Practitioner. • FBE, ESR, & CRP if inflammation is suspected • Biochemistry Consider according to clinical suspicion: • Calcium and phosphate • Protein electrophoresis • Immunoglobulins • PSA • Rheumatoid serology	• Physiotherapy • Activity modification • Analgesics and NSAIDs (see ACC guidelines booklet)	Refer if significant symptoms persisting >6/52.

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Neck:

NECK PAIN AND RADICULAR ARM PAIN WITH NEUROLOGICAL DEFICIT

Evaluation	Management	Referral Guidelines
Standard history and examination including key points: • Duration of symptoms • Presence of neurological symptoms and signs • Functional impairment • Time off work • Weight loss, loss of appetite and lethargy • Fever and sweats • Treatment to date • Previous spinal surgery • Previous malignant disease • General medical condition and medication Investigations if symptoms persist: • X-ray (AP & lateral cervical spine) • CT scan/MRI **Please note:** Medicare now provides a rebate for MRI cervical spine for cervical radiculopathy or trauma in patients over 16 years of age when requested by a General Practitioner. • FBE, ESR, & CRP if inflammation is suspected • Biochemistry Consider according to clinical suspicion: • Calcium and phosphate • Protein electrophoresis • Immunoglobulins • PSA • Rheumatoid serology		If cervical myelopathy – refer **IMMEDIATELY** – phone Orthopaedic Registrar on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre. Acute neck pain with radicular muscle power deficit, refer - Urgent. Acute neck pain with radicular sensory deficit only refer Urgent or Routine depending on severity.

NECK PAIN SECONDARY TO NEOPLASTIC DISEASE OR INFECTION

NECK PAIN WITH MYELOPATHY

Evaluation	Management	Referral Guidelines
		Refer **IMMEDIATELY** – phone Orthopaedic Registrar on 9076 2000 and/or send to The Alfred Emergency and Trauma Centre.

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HIP AND KNEE:
OSTEOARTHRITIS
INFLAMMATORY ARTHRITIS
POST TRAUMATIC ARTHRITIS
AVASCULAR NECROSIS

Evaluation	Management	Referral Guidelines
Standard history and examination including key points: • Walking distance • Rest pain & disturbance of sleep • Ability to put on shoes • Use of walking aids • Treatment including NSAIDs and analgesics • General medical conditions and medication • History of recurrent infections and prostatism • Examination for range of movement and fixed deformity **Investigations**: • X-ray (AP pelvis and lateral hip including weight bearing/standing views)	• Anti inflammatories/ analgesics/ physiotherapy • Activity modification including the use of a walking stick • Weight reduction	• Refer if significant pain, disability, sleep disturbance, unresponsive to therapy and the patient is a surgical candidate. • If infection suspected, contact Orthopaedic registrar IMMEDIATELY on 9076 2000, particularly if there are symptoms of septic arthritis (do not commence antibiotics). All referrals for hip and knee osteoarthritis attend the Osteoarthritis Hip and Knee Service (OAHKS), which is staffed by physiotherapists. OAHKS information

PREVIOUS TOTAL HIP AND KNEE REPLACEMENT
Infection, Loosening & Wear

Evaluation	Management	Referral Guidelines
Key Points: • New pain • Limp • Translucency on XR **Investigations**: • X-ray (AP pelvis and lateral hip including weight bearing/standing views)		• Pain in a previous arthroplasty should be referred fairly urgently. • If infection suspected, contact Orthopaedic registrar IMMEDIATELY on 9076 2000, particularly if there are symptoms of septic arthritis (do not commence antibiotics).

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Ankles and Feet:

ARTHRITIS

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP and lateral ankle/foot including weight bearing/standing views)	• Analgesics/anti inflammatories • Physiotherapy • Activity modification • Walking aids • Consider steroid injection	Refer if functional impairment despite conservative treatment.

PAIN & DEFORMITY IN FOREFOOT (Including Bunions)

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP and lateral foot including weight bearing/standing views) • Check Tibialis Posterior	• Modification footwear • Orthoses • Consider steroid injections for inter-metatarsal bursa/ neuroma	Refer if conservative treatment fails

PAIN & INSTABILITY IN HIND FOOT

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP and lateral foot including weight bearing/standing views)	• Check Tibialis Posterior • Modification footwear • Orthoses • Physiotherapy	Refer if conservative treatment fails

ACHILLES TENDON PATHOLOGY

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP and lateral ankle/foot including weight bearing/standing views)	• Physiotherapy • Avoid steroid injections • Heel cups/raise	Refer if conservative treatment fails

HEEL PAIN

Evaluation	Management	Referral Guidelines
• Standard history and examination • X-ray (AP and lateral ankle/foot including weight bearing/standing views) • NB: X-rays allow exclusion of some diagnoses • **NOTE:** Plantar spur on an X-ray does not imply plantar fasciitis	• Physiotherapy • Steroid injections for plantar fasciitis • Heel cups/raise	Refer if conservative treatment fails

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Miscellaneous:

NERVE ENTRAPMENT SYNDROMES

Carpal tunnel, Ulnar Neuritis & Tarsal tunnel

Evaluation	Management	Referral Guidelines
• Standard history and examination • Nerve conduction studies can be performed at The Alfred; phone 9076 2058, Fax 9076 6075.	• Consider one steroid injection for carpal tunnel • Splintage	• Refer as Urgent if muscle wasting or associated with pregnancy. • Carpal tunnel syndrome may also be referred directly to Plastic Surgery, Neurosurgery or General Surgery Clinics.

BONE AND/OR JOINT INFECTION

Evaluation	Management	Referral Guidelines
Standard history and examination • FBE • ESR • CRP	Do not commence antibiotics	Refer Urgently – phone Orthopaedic Registrar on call on 9076 2000

BONE AND SOFT TISSUE TUMOURS

Evaluation	Management	Referral Guidelines
Standard history and examination	Do not needle biopsy	Refer Urgently to St Vincent's Hospital for further management

BURSITIS

Pre-patella Bursitis, Trochanteric Bursitis & Olecranon Bursitis

Evaluation	Management	Referral Guidelines
• Standard history and examination • Acute/inflammatory, consider aspirating for diagnosis. Will either be traumatic, gouty or infected • FBE • ESR • CRP	• If acute consider aspirating for relief of symptoms • If chronic consider steroid injection	Refer if non responsive to treatment

APOPHYSITIS (eg Osgood Schlatters)

Evaluation	Management	Referral Guidelines
• Standard history and examination • Consider X-rays:	Activity modification, reassurance	Refer if does not settle

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Miscellaneous:

SYMPTOMATIC PROSTHESES (including joint replacements), RODS, PLATES, SCREWS OR PINS

Evaluation	Management	Referral Guidelines
• Pain • Prominent metal • Ulceration • X-ray—translucency or lysis around implant		• Most metal implants are not removed. • Consider referral if painful or risk refracture. • Consider removal if under 40 years. • Refer back to original provider if possible. • New or increasing pain in a previously well-functioning arthroplasty should be referred fairly urgently. • If infection suspected, contact Orthopaedic registrar IMMEDIATELY on 9076 2000, particularly if there are symptoms of septic arthritis (do not commence antibiotics).

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FRACTURES

Evaluation	Referral Guidelines
Immediate – send to The Alfred Emergency and Trauma Centre: • Unstable fractures with gross deformity • Displaced and/or angulated fractures • Open fractures • Fractures with abnormal neurology • Fractures requiring reduction	Phone the Orthopaedic Surgery Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.
Orthopaedic clinic review within 1-3 days: • Grossly swollen or comminuted fractures, including those requiring a POP to be split on day of application or at first POP check • Fractures involving joint surfaces	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.
Orthopaedic clinic review within 5-7 days: • Any fractures that have not had a definitive diagnosis made eg scaphoid, radial head, distal fibula	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.
Orthopaedic clinic review within 7-10 days: • Undisplaced fractures • Fractures that have been reduced satisfactorily	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.

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SOFT TISSUE INJURIES

Evaluation	Referral Guidelines
Immediate – send to The Alfred Emergency and Trauma Centre: • Suspected grossly unstable joint • Knee dislocation • Injury to more than one knee ligament • Acute traumatic tendon ruptures: ⇒ Biceps ⇒ Achilles ⇒ Quadriceps ⇒ Rotator cuff in younger patients with significant trauma that may be associated with upper limb fractures	Phone the Orthopaedic Surgery Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.
Orthopaedic clinic review within 1-3 days: Any soft tissue injury that may require early specialised intervention (bracing/early surgery) : • Unstable ligament injuries: ⇒ Lateral collateral ankle ligament tear ⇒ Medial collateral knee ligament tear ⇒ Acromioclavicular joint ⇒ Gamekeeper's thumb • Locked knee (inability to fully extend) - jammed bucket handle tear of meniscus • Shoulder dislocation age <25 years (first occurrence) • Scaphoid-lunate dissociations	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.
Orthopaedic clinic review within 5-7 days: • Any soft tissue injury that requires a decision regarding early mobilization: ⇒ Cruciate ligament ruptures ⇒ All other shoulder dislocations ⇒ Elbow dislocations	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.
Orthopaedic clinic review within 7-10 days: • Any soft tissue injury that is treated by immobilization: ⇒ Patella dislocation ⇒ Other immobilized ligamentous injuries (grade 2 or 3)	Urgent cases must be discussed with the Orthopaedic Surgery Registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.