Orthopaedic Outpatient Referral Guideline

Please provide a BMI for your patient when referring.

The referral should include:
- Patient full name (and any alias) and, if appropriate, the name of the parent or caregiver.
- Patient address.
- Patient telephone number (home and alternative).
- Carer contact where appropriate.
- Patient date of birth.
- Patient occupation.
- Hospital Unit Record number (UR) if known.
- Past history including details of previous treatment and investigations (photocopied results where appropriate) including x-rays.
- For patients being referred to the OPD with the same problem, the referral should contain the relevant information directed to the original consultant who will arrange an appropriate follow-up appointment at a routine clinic.
- Presenting symptoms and their duration.
- Physical findings.
- Details of any previous treatment including medications given to the patient for that condition. Include details and results of conservative therapies such as physiotherapy, podiatry etc.
- Details of any associated medical conditions which may affect the condition or treatment (eg Diabetes).
- Details of current medications and any drug allergies.
- Details of community support services in place.
- MAPT score for osteoarthritic hip and knee referrals.

This information should be detailed routinely in all referrals when sent to the Orthopaedic Outpatients Department and to a Named Consultant wherever possible, but often is not included. If this information is provided, valuable clinical time can be used seeing patients rather than attempting to gather information that was readily available to the referring doctor. Referrals which do not contain sufficient information to allow accurate grading of the priority of the referral by the Service who receives the letter will be returned to the referring doctor.

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<thead>
<tr>
<th>Diagnosis/Symptomatology</th>
<th>Evaluation</th>
<th>Management options</th>
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<tbody>
<tr>
<td>Problems are categorised by the following anatomical headings: Neck, Shoulders, Elbows, Upper limbs, Hands, Back, Pelvis, Hips, Knees, Ankle, Feet, And Miscellaneous Group</td>
<td>A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Appropriate investigation by the referrer will facilitate the referral process.</td>
<td>Specific treatments depend on specific problems identified as noted below</td>
<td>These guidelines are provided (below) to give greater clarity in situations of the primary/secondary interface of care.</td>
</tr>
</tbody>
</table>
## Orthopaedic Outpatient Referral Guidelines – V2 2019

### Diagnosis/Symptomatology

<table>
<thead>
<tr>
<th>Neck</th>
<th>Neck pain associated with radicular symptoms and neurological deficit</th>
<th>Routine history and examination noting the key points as above</th>
<th>Refer for an immediate opinion – Neurosurgery Royal Brisbane Hospital</th>
</tr>
</thead>
</table>
|      | • Neck pain associated with referred pain to the upper arm without neurological deficit. | • Duration of symptoms  
• Presence of neurological symptoms and signs including evidence of lower limb spasticity  
• Work status  
• Weight loss, appetite loss and lethargy  
• Fever and sweats  
• Treatment to date  
• Previous malignant disease  
• General medical condition. | Activity modification Analgesics NSAIDs Physiotherapy Exercise program |
|      | Investigations:  
• X-ray  
• FBC & ESR  
• Biochemistry (Consider calcium and phosphate, protein electrophoresis, immunoglobulin, PSA, Rheumatoid serology in specific cases) | If symptoms and signs persist more than 6/52 – then refer patient to RBWH (No spinal Scope of Service in WBHHS) |
|      | Shoulders | Rotator Cuff Tendonitis/Tears. | Standard history and examination particularly neurological examination.  
X-rays (standard views).  
Consider FBC & ESR. Ultrasound examination. | Anti-inflammatories. Physiotherapy. Exercise program. Consider Cortisone injections. (U/S guided by Radiologist) |
X-rays (standard views).  
<p>|      | | | Refer after six months. If shows improvement after six months continue same management for another 12/12 (No Scope of Service in Bundaberg at this time Refer patient to RBWH). |</p>
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<tr>
<td>AC joint problems</td>
<td>Standard history and examination particularly neurological examination. X-rays (standard views). Consider FBC &amp; ESR.</td>
<td>Anti-inflammatories. Physiotherapy. Cortisone injections.</td>
<td>Refer after six months if persisting symptoms. (No Scope of Service in Bundaberg at this time Refer patient to RBWH).</td>
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<tr>
<td>Recurrent dislocated shoulder/shoulder instability</td>
<td>Standard history and examination particularly neurological examination. X-rays (standard views). Consider FBC &amp; ESR. MRI if patient can afford with specialist signature.</td>
<td></td>
<td>Refer if recurrent functional instability and/or pain and has not responded to the rehab programme after three months. Consider referral after recurrent shoulder dislocation. (No Scope of Service in Bundaberg at this time Refer patient to RBWH).</td>
</tr>
<tr>
<td>Locking</td>
<td>Standard history and examination x-ray.</td>
<td>None.</td>
<td>Refer with x-ray, but consider occupation and functional disability.</td>
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<tr>
<td>Pain/stiffness in elbow</td>
<td>Standard history and examination. Consider FBC &amp; ESR.</td>
<td>Anti-inflammatories. Physiotherapy.</td>
<td>Refer if not responding to treatment after three months.</td>
</tr>
<tr>
<td>Contractures</td>
<td>Standard history and examination.</td>
<td>Splinting for symptomatic relief. Steroid Injection.</td>
<td>Refer if MCP contracture is &gt; 30° And any PIP contractures with functional impairment. Do a ‘table top test’ prior to referral.</td>
</tr>
<tr>
<td>Stenosing tenovaginitis (eg. Trigger fingers, de Quervains)</td>
<td>Standard history and examination.</td>
<td>Consider injection with steroids. Physiotherapy. Brace.</td>
<td>Refer if functional impairment or if unresponsive to treatment after one injection and splints</td>
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</tbody>
</table>

Elbows

Pain/stiffness in elbow

Wrist and hand

Contractures

Stenosing tenovaginitis (eg. Trigger fingers, de Quervains)
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<tr>
<td>Rheumatoid conditions</td>
<td>Standard history and examination</td>
<td>Consider brace. Anti-inflammatories. Activity modification. Consider steroid injection.</td>
<td>Referral to Orthopaedic Surgeon is via Rheumatologist/General Physician</td>
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<td>(cf Rheumatology Recommendations)</td>
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<tr>
<td>Basal Thumb Arthritis</td>
<td>Standard history and examination x-ray</td>
<td>Anti-inflammatories.</td>
<td>Refer after six months if fails to respond.</td>
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<td>Activity modification.</td>
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<td>Consider steroid injection.</td>
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<tr>
<td>Ganglia</td>
<td>Standard history and examination</td>
<td>Consider aspiration (18g needle) and injection of steroid. DO NOT ASPIRATE VOLAR GANGLION. Can repeat if aspiration is after 2 years.</td>
<td>Refer for symptomatic ganglia on volar aspect. Cosmesis alone usually is not a reason for referral.</td>
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<tr>
<td>Painful/Stiff Wrists</td>
<td>Standard history and examination. X-rays to include scaphoid views. Rule out rheumatoid systemic arthritis.</td>
<td>Anti-inflammatories. Trial of wrist splint. Physiotherapy</td>
<td>Refer after six months</td>
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<tr>
<td>Congenital upper limb abnormalities</td>
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<td>Refer to RBWH</td>
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<td>Back</td>
<td>• Duration of symptoms.</td>
<td>Activity modification.</td>
<td>Symptoms persisting &gt; 6/52, refer to RBWH. (No Scope of Service at WBHHS).</td>
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<td></td>
<td>• Presence of neurological symptoms and signs.</td>
<td>Analgesics and NSAIDs.</td>
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<td>• Functional impairment.</td>
<td>Physiotherapy.</td>
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<td>• Time off work.</td>
<td>Exercise program.</td>
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<td>• Wight loss, loss of appetite and lethargy.</td>
<td>Back education group.</td>
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<td>• Treatment to date.</td>
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<td>• Previous spinal surgery.</td>
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<td>• Previous malignant disease.</td>
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<td>• General medical condition and medication.</td>
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<td>• Urinary difficulties.</td>
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<td></td>
<td>• X-rays.</td>
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<td>• FBC ESR Biochemistry.</td>
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<td>(Consider calcium and phosphate, electrophoresis, immunoglobulin’s, PSA, Rheumatoid serology in specific cases).</td>
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<td>• Back pain and sciatica with neurological deficit.</td>
<td>As above</td>
<td>Refer to Neurosurgeon RBWH</td>
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<td>• Spinal stenosis with limitation of walking distance.</td>
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<td>• Back pain secondary to neoplastic disease or infection.</td>
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[Table continues]
## Hips

**Diagnosis/Symptomatology**
- Hip Arthritis
  - Osteoarthritis.
  - Inflammatory Arthritis.
  - Post Traumatic Arthritis.
  - Avascular Necrosis.

### Evaluation
- Standard history and examination:
  - Walking distance.
  - Rest pain and disturbance of sleep.
  - Ability to put on shoes.
  - Use of walking aids.
  - Treatment including NSAIDs and analgesics.
  - Previous joint surgery.
  - General medical conditions and medication.
  - History of recurrent infections and prostatism.
  - X-ray (AP pelvis, AP affected hip showing proximal 2/3 femur, and lateral affected hip).

### Management options
- Anti-inflammatories.
- Analgesics.
- Physiotherapy (where available)
- Hydrotherapy/Exercise program.
- Activity modification including the use of a walking stick.
- Home modification and use of ADC. Better Health Self-Management Program.
- Consider dietician if BMI an issue.
- Weight reduction monitoring over months.

### Referral guidelines
- Refer if significant pain, problems relating to mobility, sleep disturbance, and unresponsive to therapy over several months.

## Paediatric Hip Conditions (Perthes, SUFE, Synovitis)

### Evaluation

### Referral guidelines
- Acute referral for admission if systemically unwell, febrile, or on suspicion of SUFE. Refer to EMERGENCY DEPARTMENT.
- Otherwise re-assess at 24 hours.
- Age ranges usually:
  - Transient synovitis 18 months to 6 years.
  - Perthes 4-10 years.
  - SUFEs usually 8-14 years.
- If hip dysplastic, refer to Queensland Children's Hospital.

## Knees

### Knee Arthritis:
- Osteoarthritis.
- Inflammatory Arthritis.
- Post Traumatic Arthritis.
- Avascular Arthritis

### Evaluation
- Standard history and investigation:
  - Walking distance
  - Rest pain and sleep disturbance.
  - Use of walking aids.
  - Treatment including NSAIDs and analgesics.
  - Previous joint surgery.
  - General medical condition and medication.
  - History of recurring infections and prostatism.
  - X-rays – four standard views plus standing AP total knees.

### Management options
- Anti-inflammatories/analgesics.
- Physiotherapy/1
- Hydrotherapy.
- Activity modification including the use of a walking stick.
- Home ADC.
- Get Moving Program.
- Better Health Self-Management Program
- Home exercise program
- Diet
- Weight reduction monitoring

### Referral guidelines
- Refer if significant pain, problems relating to mobility, sleep disturbance and unresponsive to therapy over several weeks.
## Diagnosis/Symptomatology

### Post Traumatic Instability and
- Meniscal Injuries with locking knee
- Effusion
- Dislocated Patella

### Evaluation
- History of presenting complaint.
- Present Treatment
- General medical condition and medication
- X-rays – four standard views plus standing AP.

### Management options
- Analgesics/anti-inflammatories.
- Consider steroid injection.

### Referral guidelines
- Refer when identified.

## Ankles and feet

### Arthritis
- Standard history and examination.
  - X-Rays

### Evaluation
- Analgesics/anti-inflammatories.
- Consider steroid injection.

### Referral guidelines
- Refer if functional impairment despite conservative treatment after six months.

### Pain and deformity in forefoot (including bunions)
- Standard history and examination.
  - X-rays standing.
  - Weight-bearing AP

### Evaluation
- Modification footwear.
- Orthoses.
- Podiatry.

### Referral guidelines
- Refer for routine assessment if severity of symptoms warrants after three months conservative treatment.

### Pain and instability in hind foot
- Standard history and examination.
  - X-rays

### Evaluation
- Modification footwear.
- Orthoses (where available).
- Physiotherapy (where available).
- Consider steroid injection.

### Referral guidelines
- Refer if severity of symptoms warrants after three months conservative treatment.

### Achilles tendon pathology
- Standard history and examination.
  - X-rays
  - U/S

### Evaluation
- Physiotherapy (where available)
  - AVOID steroid injections.
  - Heel cups/raise (where available).

### Referral guidelines
- Refer in three months if conservative treatment fails or if patient has tender nodule.

### Heel Pain
- Standard history and examination.
  - X-rays
  - NB: Plantar spurs on an x-ray does not infer plantar fasciitis.

### Evaluation
- Physiotherapy (where available)
- Steroid injections for plantar fasciitis.
- Heel cups/raise (where available).

### Referral guidelines
- Refer after failure to respond to three months of conservative treatment.

## Paediatric deformities

### Club Foot
- Features to be looked for are fixed equinus and varus

### Evaluation
- Consider referral to Physiotherapy at 4/52 if NOT fixed deformity

### Referral guidelines
- Refer immediately to Queensland Children’s Hospital

### Calcaneo Valgus Foot
- Almost always correctable to neutral, but check the hips for stability

### Evaluation
- Reassurance. Consider referral to Physiotherapy at 4/52 if NOT fixed deformity

### Referral guidelines
- If not flexible or not looking normal by three weeks, should be referred to Queensland Children’s Hospital. Follow-up with Paediatrician.
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<td>Flat Foot</td>
<td>Under the age of three years, flat feet are normal. Ask the child to stand on tip toes. If the arch corrects, the foot is normal.</td>
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</tr>
<tr>
<td>In Toeing</td>
<td>Standard history and examination.</td>
<td>Reassurance</td>
<td>Only for a second opinion beyond walking age.</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
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<tr>
<td>Nerve Entrapment Syndromes</td>
<td>Standard history and examination</td>
<td>Consider one steroid injection for carpel tunnel. Splintage. Physiotherapy. X-ray-wrist +/- neck and nerve conduction studies.</td>
<td>Refer if muscle wasting, otherwise after three months refer routinely.</td>
</tr>
<tr>
<td>Bone and/or Joint Infection</td>
<td>Standard history and examination.</td>
<td></td>
<td>Acute referral to EMERGENCY DEPARTMENT</td>
</tr>
<tr>
<td>Bone and Soft Tissue Tumours</td>
<td>Standard history and examination.</td>
<td></td>
<td>Refer urgently if tumour or suspicion of tumour to RBWH</td>
</tr>
<tr>
<td>Bursitis (Pre Patella, Trochanteric, Olecranon)</td>
<td>Standard history and examination. Acute/inflammatory, consider aspirating for diagnosis. Will either be traumatic, gouty or infected.</td>
<td>If acute, consider aspirating for relief of symptoms. Do not incise. If chronic, consider steroid injection. Physiotherapy.</td>
<td>Refer if non-responsive to treatment after three months, and symptomatic as routine assessment</td>
</tr>
<tr>
<td>Apophysitis, eg. Osgood Schlatters, JL Disease</td>
<td>Standard history and examination. Consider X-ray.</td>
<td>Activity modification, reassurance. Consider Physiotherapy.</td>
<td>Refer if a second opinion or confirmation required.</td>
</tr>
<tr>
<td>Gait</td>
<td>Standard history and examination. Up to two years, bow legs are normal. Knock knees from age 2-5 are normal.</td>
<td>Reassurance. Consider Physiotherapy.</td>
<td>Refer for second opinion or severe deformity outside the normal age range. Refer to RBWH</td>
</tr>
<tr>
<td>Sterno Mastoid Tumour (congenital Muscular Torticollis). See Paediatric Surgery Referral Recommendations.</td>
<td>Standard history and examination.</td>
<td>Passive stretching by parent or physiotherapist.</td>
<td>Refer if failure to respond after one year of age. Refer to RBWH</td>
</tr>
</tbody>
</table>

**Enquiries**

Monday to Friday, 9am to 4pm

**Phone:**
- (07) 4325 6903 Hervey Bay and Maryborough Hospitals
- (07) 4150 2918 Bundaberg Hospital