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.

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Problems are categorised by the following anatomical headings: • Neck • Shoulders • Elbows • Upper limbs • Hands • Back • Pelvis • Hips • Knees • Ankle • Feet And Miscellaneous Group	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.	Specific treatments depend on specific problems identified as noted below	These guidelines are provided (below) to give greater clarity in situations of the primary/secondary interface of care.

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Neck			
• Mechanical neck pain without arm pain. • 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. **Investigations:** • X-ray • FBC & ESR • Biochemistry (Consider calcium and phosphate, protein electrophoresis, immunoglobulin, PSA, Rheumatoid serology in specific cases)	Activity modification Analgesics NSAIDs Physiotherapy Exercise program	If symptoms and signs persist more than 6/52 – then **refer patient to RBWH** (No spinal Scope of Service in WBHHS)
• Neck pain associated with radicular symptoms and neurological deficit • Cervical myelopathy • Neck pain secondary to malignant disease. • Neck pain secondary to infection	Routine history and examination noting the key points as above		**Refer for an immediate opinion – Neurosurgery Royal Brisbane Hospital**
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)	Refer if patient fails to respond to treatment after three months unless evidence of weakness suggestive of a gross acute rotator cuff tear. (No Scope of Service in Bundaberg at this present time **Refer patient to RBWH).**
Pain/stiffness in shoulder. Frozen shoulder.	Standard history and examination particularly neurological examination. X-rays (standard views). Consider FBC & ESR. Mention if Diabetic.	Anti-inflammatories. Physiotherapy. Consider Cortisone injections (intraartricular).	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**).

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
AC joint problems	Standard history and examination particularly neurological examination. X-rays (standard views). Consider FBC & ESR.	Anti-inflammatories. Physiotherapy. Cortisone injections.	Refer after **six months** if persisting symptoms. (No Scope of Service in Bundaberg at this time **Refer patient to RBWH**).
Recurrent dislocated shoulder/shoulder instability	Standard history and examination particularly neurological examination. X-rays (standard views). Consider FBC & ESR. MRI if patient can afford with specialist signature.		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**).
Elbows			
Tendonitis	Standard history and examination.	Consider Cortisone injection. Anti-inflammatories. Bands. Physiotherapy.	Refer if fails to respond to treatment after **four weeks or recurrence.**
Locking	Standard history and examination x-ray.	None.	Refer with x-ray, but consider occupation and functional disability.
Pain/stiffness in elbow	Standard history and examination. Consider FBC & ESR.	Anti-inflammatories. Physiotherapy.	Refer if not responding to treatment after **three months.**
Wrist and hand			
Contractures	Standard history and examination. • Duration and speed of progression. • Functional impairment. • Family history of Dupuytrens. • Previous surgery. • General medical conditions (especially diabetes, • epilepsy, liver disease).	Splinting for symptomatic relief. Steroid Injection.	Refer if MCP contracture is > 30^0 And any PIP contractures with functional impairment. Do a 'table top test' prior to referral.
Stenosing tenovaginitis (eg. Trigger fingers, de Quervains)	Standard history and examination.	Consider injection with steroids. Physiotherapy. Brace.	Refer if functional impairment or if unresponsive to treatment after one injection and splints

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Rheumatoid conditions (cf Rheumatology Recommendations).	Standard history and examination		Referral to Orthopaedic Surgeon is via Rheumatologist/ **General Physician**
Basal Thumb Arthritis	Standard history and examination x-ray	Consider brace. Anti-inflammatories. Activity modification. Consider steroid injection.	Refer after **six months** if fails to respond.
Ganglia	Standard history and examination.	Consider aspiration (18g needle) and injection of steroid. DO NOT ASPIRATE VOLAR GANGLION. Can repeat if aspiration is after 2 years.	Refer for symptomatic ganglia on volar aspect. Cosmesis alone usually is not a reason for referral.
Painful/Stiff Wrists	Standard history and examination. X-rays to include scaphoid views. Rule out rheumatoid systemic arthritis.	Anti-inflammatories. Trial of wrist splint. Physiotherapy	Refer after **six months**
Congenital upper limb abnormalities			**Refer to RBWH**
Back			
Mechanical low back pain without leg pain.	• Duration of symptoms. • Presence of neurological symptoms and signs. • Functional impairment. • Time off work. • Wight loss, loss of appetite and lethargy. • Treatment to date. • Previous spinal surgery. • Previous malignant disease. • General medical condition and medication. • Urinary difficulties. • X-rays. • FBC ESR Biochemistry. (Consider calcium and phosphate, electrophoresis, immunoglobulin's, PSA, Rheumatoid serology in specific cases).	• Activity modification. • Analgesics and NSAIDs. • Physiotherapy. • Exercise program. • Back education group.	Symptoms persisting > 6/52, **refer to RBWH. (No Scope of Service at WBHHS).**
• Back pain and sciatica with neurological deficit. • Spinal stenosis with limitation of walking distance. • Back pain secondary to neoplastic disease or infection.	As above		**Refer to Neurosurgeon RBWH**

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Hips			
Hip Arthritis • Osteoarthritis. • Inflammatory Arthritis. • Post Traumatic Arthritis. • Avascular Necrosis.	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.	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.	Refer if significant pain, problems relating to mobility, sleep disturbance, and unresponsive to therapy over several months.
Paediatric Hip Conditions (Perthes, SUFE, Synovitis)	History, examination and x-ray. Beware of pain in the knee as a symptom of hip disease.		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 synvotis 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	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.	• 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	Refer if significant pain, problems relating to mobility, sleep disturbance and unresponsive to therapy over several weeks.

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Post Traumatic Instability and • Meniscal Injuries with locking knee • Effusion • Dislocated Patella	• History of presenting complaint. • Present Treatment • General medical condition and medication • X-rays – four standard views plus standing AP.		Refer when identified
Ankles and feet			
Arthritis	Standard history and examination. • X-Rays	Analgesics/ anti-inflammatories. Physiotherapy. Activity modification. Walking aids. Consider steroid injection.	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	Modification footwear. Orthoses. Podiatry.	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	Modification footwear. Orthoses (where available). Physiotherapy (where available). Consider steroid injection.	Refer if severity of symptoms warrants after **three months** conservative treatment.
Achilles tendon pathology	Standard history and examination. • X-rays • U/S	Physiotherapy (where available) **AVOID** steroid injections. Heel cups/raise (where available).	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.	Physiotherapy (where available) Steroid injections for plantar fasciitis. Heel cups/raise (where available).	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	Consider referral to Physiotherapy at 4/52 if NOT fixed deformity	**Refer immediately to Queensland Children's Hospital**
Calcaneo Valgus Foot	Almost always correctable to neutral, but check the hips for stability	Reassurance. Consider referral to Physiotherapy at 4/52 if NOT fixed deformity	If not flexible or not looking normal by three weeks, should be **referred to Queensland Children's Hospital**. Follow-up with Paediatrician.

Diagnosis/Symptomatology	Evaluation	Management options	Referral guidelines
Flat Foot	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.		
In Toeing	Standard history and examination.	Reassurance	Only for a second opinion beyond walking age.
Miscellaneous			
Nerve Entrapment Syndromes	Standard history and examination	Consider one steroid injection for carpel tunnel. Splintage. Physiotherapy. X-ray-wrist +/- neck and nerve conduction studies.	Refer if muscle wasting, otherwise after three months refer routinely.
Bone and/or Joint Infection	Standard history and examination.		**Acute referral to EMERGENCY DEPARTMENT**
Bone and Soft Tissue Tumours	Standard history and examination. **Do not** needle biopsy		**Refer urgently if tumour or suspicion of tumour to RBWH**
Bursitis (Pre Patella, Trochanteric, Olecranon)	Standard history and examination. Acute/inflammatory, consider aspirating for diagnosis. Will either be traumatic, gouty or infected.	If acute, consider aspirating for relief of symptoms. Do not incise. If chronic, consider steroid injection. Physiotherapy.	Refer if non-responsive to treatment after three months, and symptomatic as routine assessment
Apophysitis, eg. Osgood Schlatters, JL Disease	Standard history and examination. Consider X-ray.	Activity modification, reassurance. Consider Physiotherapy.	Refer if a second opinion or confirmation required.
Gait	Standard history and examination. Up to two years, bow legs are normal. Knock knees from age 2-5 are normal.	Reassurance. Consider Physiotherapy.	Refer for second opinion or severe deformity outside the normal age range. **Refer to RBWH**
Sterno Mastoid Tumour (congenital Muscular Torticollis). See Paediatric Surgery Referral Recommendations.	Standard history and examination.	Passive stretching by parent or physiotherapist.	Refer if failure to respond after one year of age. **Refer to RBWH**

Enquiries	**Monday to Friday, 9am to 4pm**	
Phone:	(07) 4325 6903	Hervey Bay and Maryborough Hospitals
	(07) 4150 2918	Bundaberg Hospital