**GP Referral to CALHN Orthopaedic Outpatient Department**

(please print clearly)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date: | | | | | | | |
| **Patient information** | | | | | | | |
| Mr/Mrs/Miss/Ms/Dr/Prof | | Surname | | | | Previous surnames | |
| Given names | |  | | | |  | |
| Date of birth (NB no <18yrs) | | Interpreter required Y/N | | | | Language | |
| Address | | | | | | | |
|  | | | | | | Postcode | |
| Preferred phone | | Email | | | | Medicare Number/Insurance | |
| Carer details | | | | | | | |
| Blind   | Deaf   | | ATSI   | | Compensable   | | Out of CALHN zone   |
| Would patient agree to surgical intervention?   | Diabetic – please also provide current blood sugar score HBA1C <3mths   | | | | BMI | | Skin integrity issues   |
| Allergies   | Smoker   | | | Vascular risks  (please specify)   | | | Undergoing dialysis   |
| Reason for referral & history of symptoms | | | | | | | |
| Current medications | | | | | | | |
| Comments | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **General practitioner details** | | |
| Name | | Provider number |
| Clinic | | |
| Address | | |
| Phone | Fax | |
| Email | | |

Additional information required for orthopaedic assessment

|  |  |
| --- | --- |
| **Patient’s expectation of referral outcome:**  **Main site affected:**  **Diagnosis:**   Osteoarthritis   Rheumatoid arthritis   Other   Diagnosis unclear  **Basis of diagnosis:**   Clinical only   \*Mandatory\* attach x-ray and report <6 mths old - date:   Report attached  (include weight bearing views)   Other (blood results/pathology)  **Past medical history**  **Falls:** Number in last 12 months: | **History of conservative management**  (tick only those that are relevant to referral):   Simple analgesics   NSAIDs   Cox-2 inhibitors   Disease Modifying Anti-  Rheumatic Drugs (DMARDs)   Intra-articular injections  (Corticosteroid)   Prednisolone   Opioid analgaesia   Tramadol   Physiotherapy   Nutritional assessment   Occupational therapy (Activity  of Daily Living Assessment)   Podiatry / Orthotics   Home Support Services  Alternative therapies (please list)   Other: |
| **Additional relevant information**  (e.g. blood borne viruses, and psychological considerations): | |

Referral and management guidelines for osteoarthritis of the hip/knee orthopaedic surgery

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| --- |
| **Referral & Management Guidelines**  **Osteoarthritis of the Hip/Knee – Orthopaedic Surgery** |
| **Diagnosis**   * Osteoarthritis * Avascular Necrosis (Hip) * Other |
| **Evaluation**   * BMI, smoker, vascular issues, dialysis, diabetes & social supports * Range of movement * Walking distance * Rest pain & sleep disturbance * Use of walking aids * Effectiveness of NSAIDs, joint injections and analgesia, conservative management * General medical condition and impact of joint pain on health |
| **Investigations**   * <6 mths old X-rays - HIP - AP pelvis & lateral hip including weight bearing * KNEE - AP & lateral both knees, weight bearing * Bloods as appropriate (CBE and iron stores, B12, LFTs (including creatinine and eGFR) * HbA1C if diabetic |
| **Management**   * Anti-inflammatories and analgesia * Physiotherapy/exercise physiology including quad strength and pain management * Activity modification – use of walking stick or other aid * Weight reduction |
| **Triage & Referral Guidelines**  Consider referral if:   * Clinically concerned * Significant pain * Impairment or impact on function' * Unresponsive to conservative management strategies * Patient is medically fit for surgery and would consent to surgery |
| **Previous Total Hip/Knee Arthroplasty** |
| **Evaluation**   * New pain * Limp * Translucency on X-ray   **Referral -**   * Refer urgently if patient has new pain in a previous arthroplasty * If infection is suspected contact RELEVANT CONTACT (INSERT) particularly if symptoms of septic arthritis (do **not** commence antibiotics). |

Multi-attribute Arthritis Prioritisation Tool (MAPT)

1. **Do you have hip or knee pain that does not get better even when you rest (for example, while sitting)?**

None or mild pain

Moderate pain

Severe pain

Extremely severe pain

The pain is so severe that I cannot bear it

1. **Do you have hip or knee pain when you first go to bed at night that stops you going to sleep?**

No or rarely

I have pain that sometimes stops me going to sleep

I have pain that often stops me going to sleep

I have pain that stops me going to sleep most of the time

I have pain that stops me going to sleep all the time

1. **Do you have hip or knee pain that limits your walking?**

My walking is not limited by hip or knee pain

I can walk for at least 30 minutes before pain stops me

I can walk for about ten to 15 minutes before pain stops me

I can only walk for a short time (such as walking from one room to another room)

I am not able to walk at all because of my hip or knee pain

1. **Does your hip or knee make it difficult for you to look after yourself (such as washing yourself, getting dressed, going to the toilet)?**

No, I can look after myself Go to Question 6 (over the page)

There are some things I cannot do for myself

There are many things I cannot do for myself

I cannot do most things for myself

I cannot look after myself because of my hip or knee

1. **Do you get enough help with looking after yourself (such as washing yourself, getting dressed, going to the toilet)?**

I get as much help as I need

Most of the time I get enough help

Some of the time I get enough help

I rarely get enough help

I do not get enough help with looking after myself

Please answer the questions over the page.

**6. Does your hip or knee affect your enjoyment of life?**

No, or only a little

It makes it moderately difficult for me to enjoy my life

It makes it very diffi cult for me to enjoy my life

It makes it extremely difficult for me to enjoy my life

I cannot enjoy my life at all because of my hip or knee

**7. Does your hip or knee cause difficulties with your relationships with people close to you (such as wife, husband, children and close friends)?**

No, it does not cause difficulties with my relationships

It sometimes causes difficulties with my relationships

It often causes difficulties with my relationships

Most of the time it causes difficulties with my relationships

All of the time my hip or knee causes difficulties with my relationships

**8. Does your hip or knee make it difficult for your household (yourself, family and others) to manage financially?**

No, it does not affect my household finances

It makes it slightly difficult to manage financially

It makes it moderately difficult to manage financially

It makes it extremely difficult to manage financially

My household cannot manage financially at all because of my hip or knee

**9. Have you been in paid work in the last six months?**

No

Yes, my hip or knee does not make it difficult for me to work

Yes, but it is moderately difficult for me to continue to work because of my hip or knee

Yes, but it is very difficult for me to continue to work because of my hip or knee

Yes, but I have had to stop work because of my hip or knee

Yes, but working is difficult for me for other reasons

**10. Do you need to look after people who require your care (such as a sick or disabled partner or family member)?**

No

Yes, my hip or knee does not make it difficult for me to look after them

Yes, but it is moderately difficult for me to look after them because of my hip or knee

Yes, but it is very difficult for me to look after them because of my hip or knee

Yes, but I am unable to care for them because of my hip or knee

Yes, but it is diffi cult for me to look after them for other reasons

**11. Overall, is your hip or knee problem different now compared with how it was six months ago?**

It is better now

It is about the same now

It is a little worse now

It is moderately worse now

It is very much worse now