|  |  |
| --- | --- |
| * ***Malignancy suspected-refer under 2-week rule Link to 2 week rule form***
* ***Suspected fracture- refer to A&E***
* ***Inflammatory arthritis- refer urgently to early inflammatory pathway***

Urgent and Emergency Musculoskeletal Conditions Requiring Onward Referral: http://arma.uk.net/wp-content/uploads/2021/01/Urgent-emergency-MSK-conditions-requiring-onward-referral-2.pdf |  |

**SWL ORTHOPAEDIC REFERRAL FORM: Wrist and Hand**

**SECTION 1**

|  |  |
| --- | --- |
| DATE |  |
| **Name:** |  |
| **NHS Number:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Address:** |  |
| **Tel:** |  |
| **Email:** |  |
| REFERRER DETAILS |  |
| **Name:** |  |
| **Role: (GP, FCP, ACP, Consultant)** | Choose an item. |
| **Practice Code or referrer address:** |  |
| **Contact details (phone/e-mail):** |  |

|  |  |
| --- | --- |
| **COMMUNICATION & ASSISTANCE** | YES |
| **Does the patient require an interpreter?*****If yes, which language?*** | [ ]  |
| **Is the patient suitable for a telephone or video consultation?*****If no, please provide details*** |[ ]
| **Does the patient require Patient Transport?** |[ ]
| **Does patient have access to a smart phone to receive SMS/ Video Consultations?**  |[ ]

ONWARD REFERRALS

Preferred Provider: CUH, ESH, KH, SGH, SWLEOC Choose an item.

**SECTION 2**

REASON FOR REFERRAL

Past Medical History

Drug History

|  |  |
| --- | --- |
| **REASON FOR REFERRAL****Wrist and Hand** | [ ]  |
| **Side** | YES |
| **Right** |[ ]
| **Left** |[ ]
| **Bilateral** |[ ]
| **Symptoms and Effects on Quality of Life** |  |
| **Pain** |[ ]
| **Are activities of daily living significantly compromised?** |[ ]
| **Is this causing a functional problem?** |[ ]
| **Sleep disturbance** |[ ]
| **Details of Previous Treatment Related to this Condition** |  |
| **Analgesia** |[ ]
| **Activity Modification** |[ ]
| **Physio Led Rehabilitation for minimum 12 weeks** |[ ]
| **150 minutes of moderate exercise a week** |[ ]
| **Injections****If Yes, how many?** |[ ]
| **BMI**  |  |
| **Weight loss advice (if BMI > 30)** |[ ]
| **Current smoker** |[ ]
| **Smoking ceasing advice (if applicable)** |[ ]
| **Patients Expectations** |  |
| **Rehabilitation** |[ ]
| **Surgery** |[ ]
| **Injection** |[ ]

|  |  |
| --- | --- |
| **Sub-Speciality Questions**  | YES |
| **Any weakness of the hand?** |[ ]
| **Any history of pins and needles?** |[ ]
| **Patient has been engaged in shared decision making to ensure he/ she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration** | [ ]  |
| **Confirmed willingness to have surgery within the next 18 weeks, if deemed appropriate?**  | [ ]  |

|  |  |  |
| --- | --- | --- |
| **CHOOSE RELEVANT DIFERRENTIAL DIAGNOSIS** | **MANAGEMENT IN PRIMARY CARE** | **REFERRAL CRITERION** |
| **GANGLION** **Volar** [ ] **Dorsal** [ ] **Finger** [ ] **Mucoid Cyst** [ ]  |  | Had ganglion >3 months with pain that interferes with hand function |
| **CARPAL TUNNEL SYNDROME** [ ]  | Night SplintsYes [ ]  No [ ]  | Had symptoms >6 weeks + analgesics Moderate or Severe Night pain [ ] Persistent severe sensory symptoms and/or wasting and weakness [ ]  |
| **ULNAR NEURITIS/CUBITAL TUNNEL SYNDROME**[ ]  |   | Continuous sensory change/symptoms [ ] Hand weakness and/or wasting [ ]  |
| **TRIGGER FINGER/THUMB**[ ]  |   | No response/recurrence after injection [ ]  |
| **ARTHRITIS OF THE BASE OF THE THUMB** [ ]  | Splint:Yes [ ]  No [ ]  | Recurrence or no response after NSAIDs/analgesia or injection [ ]  Increase in symptoms despite treatment and significant problem with function [ ]  |
| **DUPUYTRENS CONTRACTURE** [ ]  | Heuston Tabletop test Yes [ ]  No [ ]  | Referral for Surgery for contractures over 30 deg [ ]  |
| **DE QUERVAINS** [ ]  |  | No response/recurrence after injection [ ]  |
| **CHRONIC WRIST PAIN**[ ]  | Wrist splintYes [ ]  No [ ] Hand therapyYes [ ]  No [ ]  | Failure of conservative measures [ ] Significant functional deficit [ ]  |

|  |  |
| --- | --- |
| **DIAGNOSTICS** | **YES** |
| **X-rays/USS*****Please include date and location so images can be accessed***Date:Venue: |[ ]
| **Nerve Conduction Studies*****Please include date and location so images can be accessed***Date:Venue: |[ ]
| **Blood Tests (if anything relevant)** |[ ]