

**ORTHOPAEDIC OUTPATIENT BOOKING INFORMATION FORM
GUIDELINES FOR USE**

This form must be completed and accompany the completed Outpatient Referral Form, in order for your patient to be triaged appropriately and provided with an outpatient appointment.

Urgent, semi-urgent and review appointment times are now being allocated in all Orthopaedic clinics. These are filled according to patient need, following the provision of relevant information.

History and Impairment: (eg, night pain, incidence of falls, safety issues, walking tolerance, ADLs, work issues, impact on co morbidities, carer issues etc)

Please provide details of relevant current history, date of onset and impairments related directly to the area of concern. This information supports timely triage decisions.

Examination Findings: (eg, ROM, WB status, strength, gait pattern, neurological changes, special tests etc)

This information will enhance triage decisions.

3. Provisional / Working Diagnosis:

Please provide the current working diagnosis for your patient.

4. Primary Purpose of Referral: *Please complete as an appropriate appointment slot can then be allocated.*

- Management/Treatment
 Diagnosis
 Review
 2nd opinion
 Other (specify).....

5. Area of Concern: Please tick area to be assessed. The minimum investigations and reports required, for the referral to be accepted, are outlined below. Hard copies **MUST** accompany the patient to the outpatient appointment.

An appointment cannot be made for your patient without these minimum investigations and reports, accompanying the referral. Your patient can then be triaged appropriately. This will reduce the need for call back appointments to review the investigation results, and will significantly reduce overall clinic waiting times.

| <u>Hip</u> | <u>Knee</u> | <u>Foot & Ankle</u> | <u>Shoulder</u> | <u>Elbow to Wrist</u> | <u>Other</u> |
|---|---|---|--|--|-------------------------------|
| XR – Charnley view AP Pelvis XR – Lateral Hip | XR – PA weightbearing XR – Lateral XR – Notch (intercondylar) View XR – Skyline view | If foot – weightbearing AP, Oblique and Lateral views If ankle – Weightbearing AP, Mortise and Lateral views | XR – AP and Lateral and Ultrasound Shoulder Special views as required | XR – AP and Lateral of region Special views (eg Scaphoid) as required | XR – AP and Lateral of region |

6. Conservative Treatment to Date: Please tick the appropriate box/boxes. Details of these interventions **MUST** be included for referral to be accepted so that the patient can be directed appropriately.

| <u>Medications</u> | <u>Injections</u> | <u>Physiotherapy</u> | <u>Hydrotherapy</u> | <u>Orthotics</u> | <u>Other</u> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Details/Results: *Please comment on the effectiveness of the treatment to date.*

Please note: Your patient may also be seen, by our senior physiotherapists in clinic, to optimise conservative management, access and referrals.

| | |
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| Office Use | |
| <input type="checkbox"/> | <input type="checkbox"/> |

ORTHOPAEDIC OUTPATIENT BOOKING INFORMATION FORM
PATIENT INFORMATION:

NAME:

DoB:

Austin UR No.:

1. History and Impairment: (e.g, night pain, incidence of falls, safety issues, walking tolerance, ADLs, work issues, impact on co morbidities etc)

2. Examination Findings: (e.g, ROM, WB status, strength, gait pattern, neurological changes, special tests etc)

3. Provisional / Working Diagnosis:

4. Primary Purpose of Referral:

Management/Treatment
 Diagnosis
 Review
 2nd opinion
 Other (specify)

5. Area of Concern: Please tick area to be assessed. The minimum investigations and reports required, for the referral to be accepted, are outlined below. Hard copies MUST accompany the patient to the outpatient appointment.

| Hip | Knee | Foot & Ankle | Shoulder | Elbow to Wrist | Other |
|---|--|---|--|---|----------------------------------|
| ↓ | ↓ | ↓ | ↓ | ↓ | ↓ |
| XR – Charnley view AP Pelvis XR – Lateral Hip | XR – PA weightbearing XR – Lateral XR – Notch (intercondylar) View XR – Skyline view | If foot – weightbearing AP, Oblique and Lateral views If ankle – Weightbearing AP, Mortise and Lateral views | XR – AP and Lateral and Ultrasound Shoulder Special views as required | XR – AP and Lateral of region Special views (eg Scaphoid) as required | XR – AP and Lateral of region |

6. Conservative Treatment to Date: Please tick the appropriate box/boxes. Details of these interventions MUST be included for referral to be accepted so that the patient can be directed appropriately.

| Medications | Injections | Physiotherapy | Hydrotherapy | Orthotics | Other |
|-------------|------------|---------------|--------------|-----------|-------|
| ↓ | ↓ | ↓ | ↓ | ↓ | ↓ |

Details/Results:

Please note: Your patient may also be seen, by our senior physiotherapists in clinic, to optimise conservative management, access and referrals.

Office Use

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