WA Referral Access Criteria: Orthopaedics (Adult)

Please read the information below prior to providing feedback on the Orthopaedics (Adult) Referral Access Criteria.

Important information:

- The intent of this consultation is to facilitate additional opportunity to ensure the perspectives of the following stakeholders are captured during development of the Orthopaedics (Adult) Referral Access Criteria (RAC) for public specialist outpatient services in WA:
  - Community GPs, Royal Australian College of GPs, Aboriginal Health Council of WA / Aboriginal Medical Service
  - Other relevant Medical Practitioners
- The information within the document has been developed by a Clinical Working Group comprising Orthopaedics (Adult) Heads of Department and nominated Senior Clinicians in WA.
- This is a consultation document only. The final changes to the RAC will be updated on the WA Health RAC website for use by GPs/Primary Care referrers once endorsed.

Instructions for providing feedback:

- Please provide feedback by 15 November 2024 via the RAC development form (external site)

Next Steps:

- Feedback will be reviewed by the Orthopaedics (Adult) Clinical Working Group and the RAC will be progressed for development. You will be notified of the outcome of your feedback following final approval of the RAC.

If you have any issues or queries, please provide detail in the RAC development form (external site).

Thank you for taking the time to provide feedback, it is appreciated.

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If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Dislocations (including elbow)
- Acute tendon rupture
- Neurovascular compromise
- Retained foreign bodies in acute injury
- Suspected compartment syndrome
- Suspected septic joint including native or prosthetic joint infection

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures, even with adequate alignment, should be discussed with the on-call registrar or referred to local fracture clinic (if available)
- Failed internal fixation
- AC joint dislocations
- Acute shoulder instability (i.e. first traumatic dislocation)
- Acute loss of function with massive rotator cuff tear (i.e. full tear of at least 2 out of 4 rotator cuff tendons OR >5cm diameter rotator cuff tear)

Clinical Indication for Outpatient Referral	• Suspected malignancy
	• The following conditions not responding to maximal conservative management:
	  ○ Osteoarthritis
	  ○ AC joint pathology
	  ○ Rotator cuff pathology
	  ○ Recurrent shoulder instability
	  ○ Shoulder impingement/bursitis
	  ○ Elbow tendinopathy (golfers/tennis elbow)
	  ○ Chronic elbow instability
	• Any of the following symptoms persist despite maximal conservative management:
	  ○ Pain
	  ○ Reduced ROM/strength
	  ○ Impaired functional ability/ADLs

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, and duration of symptoms • Any relevant injury details (e.g. date, mechanism, severity, recurrence, evolution of injury) • Degree of functional impairment (e.g. impact on ADLs /ability to work) • Current medication list • Any known allergies • Details of previous treatment and outcome (e.g. physiotherapy, injections trialled) Examination • Shoulder/Elbow ROM • Neurological examination Investigations

Elbow and shoulder conditions	
	• X-ray– AP & lateral shoulder/elbow • Ultrasound (US) if suspected rotator cuff pathology or shoulder impingement/bursitis **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Relevant allied health report Investigations • If inflammation/infection suspected ○ FBC/ESR/CRP • CT/MRI according to clinical suspicion • Radiological reports where Ultrasound-guided subacromial injections have been trialed
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • Shoulder dislocation in a patient with suspected or identified rotator cuff tear • Acute full thickness cuff tear with loss of active ROM • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Recurrent shoulder dislocation/instability • Chronic elbow instability • Disproportionate severe pain or disability persists despite maximal conservative management
Category 3 Appointment within 365 days	• Chronic AC joint conditions • Degenerative rotator cuff or tendinopathy • Subacromial impingement/bursitis • Pain/stiffness in elbow • Elbow tendinopathy (golfers/tennis elbow) • Calcific tendonitis • Tendonitis/bursitis • Shoulder osteoarthritis • Shoulder adhesive capsulitis (frozen shoulder) • Mild to moderate pain or disability persists despite maximal conservative management
Exclusions for elbow and shoulder conditions	• Nil

Elbow and shoulder conditions	

Useful information for referring practitioners (non-exhaustive list)	• Ensure alternative causes for shoulder pain have been considered, these may include inflammatory arthritis, or suspected multiple myeloma.
	  ○ History of inflammatory disease – consider referral to Rheumatology, see Clinician Assist WA: Rheumatology
	• Rule out spinal causes of pain, i.e. cervical radiculopathy
	• Please note where appropriate and available, category 2 and 3 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist (ASP) at the ASP clinic in consultation with the surgeon. Outcomes may include provision of appropriate non-surgical management plans, discussion or appointment with a surgeon, or discharge
	
	Conservative management strategies
	• Referral to physiotherapy. See Clinician Assist WA: Physiotherapy Requests
	  ○ 3 months physiotherapy should be considered for all shoulder impingement/bursitis presentations
	• Referral to hand therapy (where appropriate) See Clinician Assist WA: Occupational Therapy Requests or Clinician Assist WA: Physiotherapy Requests
	• Analgesics and anti-inflammatory medications (unless contraindicated)
	• Consider steroid injection (where appropriate, unless contraindicated)
	• For shoulder impingement/bursitis with no rotator cuff tear on USS
	  ○ Consider up to two ultrasound-guided sub-acromial steroid injection (unless contraindicated)
	
	Clinical Resources
	• See Australian Journal of General Practice: Lateral epicondylitis– Current concepts (2020)
	• See Australian Journal of General Practice: Idiopathic Frozen Shoulder (2019)

Forefoot pain/deformity

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Dislocations
- Neurovascular compromise
- Suspected septic joint

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute tendon rupture in forefoot
- Failed internal fixation
- Acute/suspected Charcot Neuroarthropathy OR Charcot Neuroarthropathy with associated foot ulceration – referral to Multidisciplinary Foot Ulcer Clinic.
    - See Clinician Assist WA: Multidisciplinary Foot Ulcer Team

Clinical Indication for Outpatient Referral	• Acute closed metatarsal and toe fractures with adequate alignment
	• The following conditions with callosities, deformity, or persistent pain/limited ROM persisting despite 3-month trial of maximal conservative management:
	  ○ Claw/hammer toes
	  ○ Hallux rigidus/1st MTPJ arthritis, for example:
	  ○ Hallux valgus/bunions
	  ○ Metatarsalgia
	  ○ Morton's Neuroma that has failed local anaesthesia/steroid injection (where not contraindicated)
	• Symptoms such as swelling, pain with walking/weight-bearing impacting on functional ability/ADLs persist despite 3-month trial of maximal conservative management

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, and duration of symptoms (e.g. pain, tingling, deformity, aggravating and relieving factors) • Degree of functional impairment (e.g. impact on exercise tolerance/ADLs/ability to work) • Current medication list • Any known allergies • Details of previous treatment and outcome including any trial of orthoses and/or local anaesthetic/steroid injection Examination • Neurological examination Investigations • X-ray– weight bearing views of ankle/foot (AP, lateral, and oblique) ○ Unless for claw/hammer toes only– Plain X-ray • HbA1C only if diabetes suspected **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.**

Forefoot pain/deformity	
	If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Previous surgical history • Multidisciplinary Foot Ulcer clinic or podiatrist reports Examination • BMI
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • Acute closed metatarsal and toe fractures with adequate alignment • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Pain or deformity associated with progressive neuropathy • Disproportionate severe pain or disability (e.g. impacting ability to walk unaided or walk a functional distance) persists despite maximal conservative management
Category 3 Appointment within 365 days	• Mild to moderate pain or disability persists despite maximal conservative management

Exclusions for forefoot pain/deformity	• Ganglia that is proven to be non-malignant on imaging
	  ○ unless causing compressive nerve symptoms, pain, or functional disability
	• Diabetic foot ulcers (including associated with Charcot)- referral to Multidisciplinary Foot Ulcer Clinic.
	  ○ See Clinician Assist WA: Multidisciplinary Foot Ulcer Team

Useful information for referring practitioners (non-exhaustive list)	• Diabetic patients should also be referred to Multidisciplinary Diabetic Foot Unit if not already linked in. • Please note that ultrasound (US) for Morton's Neuroma is inaccurate as it leads to false positives • Please note where appropriate and available, category 2 and 3 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist (ASP) at the ASP clinic in consultation with the surgeon. Outcomes may include provision of appropriate non-surgical management plans, discussion or appointment with a surgeon, or discharge Conservative management strategies • Referral to community podiatry and/or physiotherapy unless clearly requires surgery. ○ See Clinician Assist WA: Podiatry Requests or Clinician Assist WA: Physiotherapy Requests • Appropriate footwear (e.g. extra depth/width) • Orthotics/spacer/toe props as indicated • Analgesia/anti-inflammatory medicines (unless contraindicated)

Forefoot pain/deformity	
	• Consider steroid injections for intermetatarsal bursae/neuroma NB: Intermetatarsal bursae/neuroma (Morton's Neuroma) will not be considered for an outpatient appointment without a trial of local anaesthetic or steroid injection (unless contraindicated) • Consider referral for (Pulsed) Radiofrequency therapy for intermetatarsal bursae/neuroma. See Clinician Assist WA: Pain Management

Hand and wrist pain/deformity

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Amputations
- Complex injuries (e.g. crush injuries, multi-fracture)
- Dislocations
- Laceration with tendon injury/rupture
- High pressure injury (e.g. injection injury)
- Neurovascular compromise
- Suspected septic joint
- Suspected compartment syndrome
- Suspected necrotising fasciitis
- Upper limb cellulitis with suspicion of sepsis or septic shock, or not responding to oral antibiotics
- Infectious flexor tenosynovitis
- Acutely exposed fixation plates (e.g. post-fall)
- Fracture non-union requiring flap coverage

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures, even with adequate alignment, should be discussed with the on-call registrar or referred to local fracture clinic (if available)
    - Noting that for best outcomes, a patient should be seen within 3 days of injury
- Failed internal fixation
- Closed tendon rupture

Clinical Indication for Outpatient Referral	• Scaphoid non-union
	• The following conditions not responding to maximal conservative management:
	  ○ Basal thumb arthritis
	  ○ Wrist arthritis
	  ○ De Quervain's tenosynovitis
	  ○ Dupuytren's contracture
	  ○ Ganglia with persisting symptoms (paraesthesia, weakness, or pain) causing functional impairment
	  ○ Triangular Fibrocartilage Complex (TFCC) injury
	  ○ Painful/stiff wrist impacting function
	  ○ Chronic ligament instability (e.g. scapho-lunate)
	  ○ Stenosing tenosynovitis (trigger finger)
	• Any of the following symptoms persist despite maximal conservative management:
	  ○ Pain
	  ○ Reduced ROM/strength
	  ○ Impaired functional ability/ADLs

Mandatory Referral Information *Required for accurate and timely clinical triage*	History • Relevant history, onset, duration, and severity of symptoms • Degree of functional impairment (e.g. impact on ADLs /ability to work) • Current medication list • Any known allergies Examination

Hand and wrist pain/deformity	
Referral will be returned if information is not included	• No defined criteria Investigations • X-ray– for arthritis, TFCC, chronic ligament instability • X-ray– for painful/stiff wrist (consider scaphoid views) **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.)**

Highly Desirable Referral Information
 	
**The inclusion or exclusion of this information will not impact the referral being accepted.*
	History
	• Details of previous treatment and outcome (e.g. splinting, hand therapy, surgery, allied health reports)
	• Smoking status
	
	Examination
	• Describe functional assessment (e.g. pinch grip, knob grip, key grip, pen grip)
	• Functional ROM
	
	Investigations
	• For painful/stiff wrist without diagnosis:
	  ○ FBC
	  ○ eGFR
	  ○ Uric acid
	  ○ ESR & CRP results if inflammation is suspected
	• If performed, for ganglion only– Ultrasound (US) to clarify presence of cyst

Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • Scaphoid non-union where injury is <3 months • Skin breakdown and/or infection secondary to severe contracture • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Secondary hand surgery >6 weeks after the injury • Scaphoid non-union where injury is >3 months • TFCC injury with instability • Stenosing tenosynovitis persisting despite maximal conservative management (e.g. trigger finger fixed in full flexion or newly fixed trigger finger) • Disproportionate severe pain or functional disability persists despite maximal conservative management (e.g. major impacts on ADLs and/or employment): ○ E.g. De Quervain's, mal-union affecting function, basal thumb arthritis
Category 3	• Dupuytren's contracture at any joint associated with functional disability

Hand and wrist pain/deformity	
Appointment within 365 days	• Contracture at multiple joints or recurrence after surgery with functional impairment • TFCC injury without instability • Symptomatic or enlarging ganglion of the hand • Chronic ligament instability • Pain or functional deformity associated with inflammatory arthropathy • Mild to moderate pain or disability persists despite maximal conservative management
Exclusions for hand and wrist pain/deformity	• Dupuytren's nodules without presence of functional impairment or contracture
Useful information for referring practitioners (non-exhaustive list)	• Please note hand and wrist referrals can be managed by the following specialties and will be triaged in line with local agreements and in a unified manner by all specialities concerned: ○ Plastic and Reconstructive Surgery • History of inflammatory disease – consider referral to Rheumatology, see Clinician Assist WA: Rheumatology Conservative management strategies • Consider splinting and referral to hand therapy where appropriate. See Clinician Assist WA: Occupational Therapy Requests or Clinician Assist WA: Physiotherapy Requests • Consider corticosteroid injections where appropriate (unless contraindicated) Clinical Resources • See Australian Journal of General Practice: Basal thumb arthritis (2020) • See Australian Journal of General Practice: De Quervain's Tenosynovitis (2019)

Hip pain

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity including suspected neck of femur fractures
- Dislocations
- Acute tendon rupture
- Neurovascular compromise
- Suspected septic joint

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures, even with adequate alignment, should be discussed with the on-call registrar or referred to local fracture clinic (if available)
- Failed internal fixation

Clinical Indication for Outpatient Referral	• Osteonecrosis
	• The following conditions/presentations not responding to maximal conservative management:
	  ○ Osteoarthritis
	  ○ Bursitis
	  ○ Femoro-acetabular impingement (FAI)
	  ○ Persistent pain
	  ○ Reduced weightbearing or ROM

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, and duration of symptoms • Degree of functional impairment (e.g. impact on mobility/exercise tolerance/ADLs/ability to put on shoes/ability to work) • Current medication list • Any known allergies • Details of previous treatment and outcome (e.g. medications, allied health, steroid injections, surgery) Examination • No defined criteria Investigations • HbA1c (for diabetic patient referral only) • X-ray– AP pelvis and hip • Ultrasound (US) – only for bursitis or gluteal tendinopathy **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**

Hip pain	

Highly Desirable Referral Information
 	
**The inclusion or exclusion of this information will not impact the referral being accepted.*
	History
	• Smoking status
	• Alcohol and other drugs history including type, amount, and frequency
	
	Examination
	• Height, weight, and BMI
	
	Investigations
	• Where relevant:
	  • FBC, ESR, CRP, Fe studies results
	  • U&E / LFT / eGFR
	• Where performed, MRI results if osteonecrosis is suspected

Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • Ongoing pain despite internal fixation • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Radiological evidence of osteonecrosis of hip <60 years of age • Gradual onset pain in previously well-functioning arthroplasty • Acetabular protrusion • Disproportionate severe pain or functional disability (e.g. impacting ability to walk unaided or walk a functional distance) persists despite maximal conservative management
Category 3 Appointment within 365 days	• Labral tear • Mild to moderate pain or disability persists despite maximal conservative management
Exclusions for hip pain	• Nil
Useful information for referring practitioners (non-exhaustive list)	• Smoking is a relative contraindication to hip and knee arthroplasty surgery • BMI >40 is a relative contraindication to arthroplasty • Consider referral to physiotherapy for conservative management prior to referral for Orthopaedic opinion. See Clinician Assist WA: Physiotherapy Requests Clinical resources • See RACGP Clinical guidelines: Diagnosis and management of hip and knee osteoarthritis

Knee pain

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Dislocations including multi-ligament injury
- Tendon rupture
- Neurovascular compromise
- Suspected septic joint

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures, even with adequate alignment, should be discussed with the on-call registrar or referred to local fracture clinic (if available)
- Failed internal fixation
- Acutely swollen knee after trauma

Clinical Indication for Outpatient Referral	• Acute obstructed/locked knee (unable to reach full extension)
	• Knee ligament injury, e.g. chronic/previous knee ligament injury
	• The following conditions/presentations not responding to maximal conservative management:
	  ○ Osteoarthritis
	  ○ Persistent pain
	  ○ Reduced weightbearing or ROM
	  ○ Knee locking, creaking or crepitus
	  ○ Instability or feeling of knee giving way (e.g. patella instability)
	  ○ Functional impairment

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, and duration of symptoms (e.g. injury, pain, haemarthrosis/effusion, locking, intermittent stiffness, instability) • Degree of functional impairment (e.g. impact on mobility/exercise tolerance/ADLs/ability to put on shoes/ability to work) • Current medication list • Any known allergies • Details of previous treatment and outcome including non-operative management Examination • No defined criteria Investigations • HbA1c (diabetic patient referral only) • X-ray – Bilateral knee weight bearing (AP, lateral and skyline) **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.**

Knee pain	
	If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.

Highly Desirable Referral Information
 	
**The inclusion or exclusion of this information will not impact the referral being accepted.*
	History
	• Smoking status
	• Alcohol and other drugs history including type, amount, and frequency
	
	Examination
	• Height, weight, and BMI
	• Functional ROM
	
	Investigations
	• Where relevant:
	  ○ FBC, ESR, CRP if concerns for infection
	  ○ Fe studies, if indicated by history
	  ○ Uric acid if relevant
	• Investigations for inflammatory arthropathy
	• Where completed, MRI results for suspected locked knee or significant internal or ligamentous derangement

Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • New pain in previously well-functioning arthroplasty • Acute obstructed/locked knee (unable to reach full extension) • Knee ligament injury (e.g. ACL, MCL) • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Functional instability of knee with or without pain (e.g. patella instability) • Effusion of unknown origin • Disproportionate severe pain or functional disability (e.g. impacting ability to walk unaided or walk a functional distance) persists despite maximal conservative management
Category 3 Appointment within 365 days	• Meniscal injuries (in the absence of locking) • Mild to moderate pain or disability persists despite maximal conservative management
Exclusions for knee pain	• Nil
Useful information for referring practitioners (non-exhaustive list)	• Smoking is a relative contraindication to hip and knee arthroplasty surgery • BMI >40 is a relative contraindication to arthroplasty • Consider referral to physiotherapy for conservative management prior to referral for Orthopaedic opinion. See Clinician Assist WA: Physiotherapy Requests Clinical resources • Australian Commissions on Safety and Quality in Health Care: Osteoarthritis of the knee clinical care standard (2017) • Australian Commissions on Safety and Quality in Health Care: Osteoarthritis of the Knee– decision support tool (2019) • See RACGP, Clinical guidelines, Diagnosis and management of hip and knee osteoarthritis

Midfoot, hindfoot, and ankle pain/deformity

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Dislocations
- Acute tendon rupture
- Neurovascular compromise
- Suspected septic joint

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures, even with adequate alignment, should be discussed with the on-call registrar or referred to local fracture clinic (if available)
- Failed internal fixation
- Acute/suspected Charcot Neuroarthropathy OR Charcot Neuroarthropathy with associated foot ulceration – referral to Multidisciplinary Foot Ulcer Clinic.
    - See Clinician Assist WA: Multidisciplinary Foot Ulcer Team

Clinical Indication for Outpatient Referral	• The following conditions/presentations not responding to at least 3-month trial of maximal conservative management:
	  ○ Osteoarthritis
	  ○ Achilles tendon pathology
	  ○ Heel pain
	  ○ Flat feet (pes planus), acquired or rigid
	  ○ Functional impairment
	• Pain or deformity associated with stable Charcot or progressive neuropathy

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, duration, and severity of symptoms (e.g. swelling, deformity, acquired or developmental) • Degree of functional impairment (e.g. impact on exercise tolerance/ADLs/ability to work) • Current medication list • Any known allergies • Details of previous treatment and outcome (e.g. insoles, physiotherapy, steroid injections) Examination • For flat feet only– Assess hindfoot movement for rigidity vs flexibility Investigations • HbA1c for diabetic patients only • X-ray– Weight bearing ankle/foot (AP and lateral) **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.**

Midfoot, hindfoot, and ankle pain/deformity	
	If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.

Highly Desirable Referral Information
 	
**The inclusion or exclusion of this information will not impact the referral being accepted.*
	History
	• Occupational history
	• Smoking status
	• Alcohol and other drugs history including type, amount, and frequency
	• High risk foot clinic or podiatrist reports
	
	Examination
	• Functional ROM
	• BMI
	• Where relevant, neurological examination or nerve irritation signs
	
	Investigations
	• The following where relevant:
	  ○ HbA1c
	  ○ FBC
	  ○ U&E / LFT / eGFR
	  ○ ESR / CRP
	  ○ Uric acid

Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Suspected malignancy • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Presence of osteonecrosis • Pain or deformity associated with stable Charcot or progressive neuropathy • Disproportionate severe pain or functional disability (e.g. impacting ability to walk unaided or walk a functional distance) persists despite maximal conservative management
Category 3 Appointment within 365 days	• Mild to moderate pain or disability persists despite maximal conservative management • Plantar Fasciitis • Flat foot
Exclusions for midfoot, hindfoot, and ankle pain/deformity	• Acute/suspected Charcot OR Charcot neuroarthropathy with ulceration should be referred to Multidisciplinary Foot Ulcer Clinic ○ See Clinician Assist WA: Multidisciplinary Foot Ulcer Team
Useful information for referring practitioners (non-exhaustive list)	• Plantar fasciitis is often a self-limiting disease and will improve in 6 to 24 months from the onset without specific treatment. NB: Plantar spurs on an X-ray does not infer plantar fasciitis • Please note that where appropriate and available, category 2 and 3 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist and/or nursing practitioner service, in consultation with the surgeon. This may include initial assessment and management by associated public allied health and/or nursing, which may either expedite or negate the need to see the public medical specialist. • For acute or suspected Achilles tendon rupture:

Midfoot, hindfoot, and ankle pain/deformity

- Back slab or moon boot
- Review in emergency or fracture clinic.

- For suspected or confirmed acute Charcot Neuroarthropathy:
  - Immediate referral to MDFU Clinic is recommended, see Clinician Assist WA: Multidisciplinary Foot Ulcer Team
  - GP to advise non-weight bearing

Conservative management strategies

- Consider referral to community podiatry (e.g. debridement of corn/callus) and/or physiotherapy unless clearly requires surgery.
  - See Clinician Assist WA: Podiatry Requests or Clinician Assist WA: Physiotherapy Requests
- Appropriate footwear (e.g. extra depth/width)
- Orthotics/arch supports/soft heel pads as indicated
- Analgesia/anti-inflammatory medicines (unless contraindicated)
- Ultrasound-guided steroid injection (unless contraindicated)
- For chronic/stable Charcot Neuroarthropathy, consider:
  - Accommodative orthotics
  - Orthopaedic/custom footwear with rocker sole or CROW Boot.
  - See Clinician Assist WA: Podiatry Requests

Clinical Resources

- See Australian Family Physician: Heel pain- a practical approach (2015)
- See Australian Journal of General Practice: The Achilles Tendon (2020)
- See Clinician Assist WA: Multidisciplinary Foot Ulcer Team
- See Clinician Assist WA: Foot Screening in Diabetes

Peripheral nerve palsies and compression/entrapments (Orthopaedics)

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Trauma with neurovascular compromise
- Suspected acute compartment syndrome

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Symptomatic benign or malignant lesion

Clinical Indication for Outpatient Referral	• Peripheral nerve palsies and compression/entrapments not responsive to conservative management, e.g.:
	  ○ Carpal tunnel syndrome
	  ○ Ulnar nerve entrapment
	  ○ Posterior interosseous nerve syndrome
	  ○ Common peroneal nerve palsy
	  ○ Tarsal tunnel syndrome

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, severity, and duration of symptoms (e.g. handedness, pain, numbness, altered sensation, frequency) • Degree of functional impairment (e.g. impact on employment/ADLs) • Current medication list • Any known allergies • Details of previous treatment and outcome (e.g. allied health input and steroid injections) Examination • Sensory or motor deficit distribution e.g. median, ulnar, radial nerves Investigations • No defined criteria **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Details of smoking/vaping status • Please advise whether or not your patient is taking any anti-platelets or anti-coagulants ○ If so, please state the indication • Occupational Therapy/Physiotherapy report

Peripheral nerve palsies and compression/entrapments (Orthopaedics)	
	Examination • BMI • Consider ultrasound (US) if suspected mass causing compression. NB: Otherwise, routine US is not required as a diagnostic tool for compression neuropathy • Nerve conduction studies (NCS) if performed (NCS will support accurate triage urgency) • CT spine (only where suspecting central compression pathology)
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	

Category 1
Appointment within 30 days
	• Sudden onset severe symptoms suggestive of acute nerve compression without trauma or acute event
	• Peripheral nerve compression syndrome or palsy with:
	  ○ rapidly progressing and/or severe neurological deficit *OR*
	  ○ associated with disabling pain syndrome
	• Pressure from external lesion

Category 2 Appointment within 90 days	• Frequent and/or progressive peripheral nerve compressive symptoms or palsy with corresponding clinical signs • Recurrence of significant symptoms or clinical signs after surgical decompression • Peripheral nerve entrapment syndromes or palsy with severe pain
Category 3 Appointment within 365 days	• Intermittent or mild symptoms of peripheral nerve compression or palsy failing to respond to conservative management and considered to warrant assessment for surgical management
Exclusions for peripheral nerve palsies and compressions/entrapments (Orthopaedics)	• Thoracic Outlet Syndrome, please refer to Vascular specialty.

Useful information for referring practitioners (non-exhaustive list)	• Routine ultrasound scans are not indicated for the diagnosis of peripheral nerve compression or entrapment
	• Carpal Tunnel Syndrome can be referred to the following specialties and will be triaged in line with local agreements and in a unified manner by all specialities concerned:
	  ○ Orthopaedics
	  ○ Plastic and Reconstructive Surgery
	  ○ Neurosurgery
	  ○ General Surgery
	• Diabetic peripheral neuropathy will require comprehensive diabetic management.
	  ○ See Clinician Assist WA: Peripheral Neuropathy
	
	Conservative management strategies to consider:
	• Consider:
	  ○ Treating underlying causes, e.g. Vitamin B12 deficiency, alcohol excess, diabetes
	  ○ Analgesia for neuropathy, e.g. SNRI, TCAs, antiepileptics
	  ○ Hand therapy. See Clinician Assist WA: Occupational Therapy Requests or Clinician Assist WA: Physiotherapy Requests

Peripheral nerve palsies and compression/entrapments (Orthopaedics)	
	○ Splinting ○ Steroid injection if not contraindicated

Scoliosis and kyphosis

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Nil

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Nil

Clinical Indication for Outpatient Referral	Aged 14-30 years and has one of the following: • Significant scoliosis (Cobb angle >10 degrees) • Progressive deformity/scoliosis, i.e. Cobb angle increased by >5 degrees in six months • Scheuermann's kyphosis with persisting pain or kyphosis NB: Patients under 14 years of age should be referred to Perth Children's Hospital. See Perth Children's Hospital Pre-referral Guidelines: Scoliosis
Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Presence/absence of concerning neurological features • Degree of functional impairment (e.g. impact on employment/ADLs) • Current medication list • Any known allergies • For female patients – Menarchal status OR date of menarche if post-menarchal Examination • Leg length discrepancy • Shoulder, trunk, waist asymmetry Investigations • Scoliogram (X-ray)– Standing PA full length of spine with report stating Cobb angle NB: There is no role for CT in the assessment of scoliosis or kyphosis **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Relevant history, onset, severity, and duration of symptoms (e.g. pain, frequency, associated diseases) • Details of previous treatment and outcome (e.g. allied health input and steroid injections)

Scoliosis and kyphosis	
	• Relevant family history associated with condition Examination • Risser grade
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Massive lateral curve (>50 degrees) in skeletally immature patient
Category 2 Appointment within 90 days	• Cobb angle increased by >5 degrees in six months • All scoliosis confirmed on X-ray with Cobb angle >20 degrees AND patient has further growth potential • Scheuermann's kyphosis with persisting pain or kyphosis exceeding 60 degrees AND patient has further growth potential • Failed internal fixation
Category 3 Appointment within 365 days	• All scoliosis confirmed on X-ray with Cobb angle >10 degrees • All scoliosis confirmed on X-ray with Cobb angle >20 degrees in the skeletally mature patient • Scheuermann's kyphosis with persisting pain or kyphosis exceeding 60 degrees in the skeletally mature patient • Symptoms persist or progress despite conservative management
Exclusions for scoliosis and kyphosis	• All curves <10 degrees do not meet the threshold to be considered scoliosis. Advise to monitor and X-ray in 9-12 months to review.
Useful information for referring practitioners (non-exhaustive list)	• For patients <14 years of age, see Perth Children's Hospital Pre-referral Guidelines: Scoliosis

Spine (Orthopaedics)

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Symptomatic benign or malignant space-occupying lesion
- Significant neurological compromise (e.g. acute foot drop)
- Suspected cauda equina syndrome
- Vascular compromise
- Suspected septic joint
- Axial spine pain or disorder with red flags (e.g. Foot drop, bowel/bladder symptoms, IVDU, steroids, fever, anticoagulants, trauma)

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Failed internal fixation- requires discussion with on-call registrar to triage appropriately

Clinical Indication for Outpatient Referral	• The following presentations in the absence of red flags:
	  ○ Moderate to severe or progressive sciatica with neurological deficit AND not responding to a minimum of 8 weeks of conservative management
	  ○ Significant or progressive neurogenic claudication/limitation of walking distance (spinal stenosis)
	  ○ Significant or progressive functional impairment AND not responding to a minimum of 8 weeks of conservative management
	  ○ Spondylolisthesis with lower limb neurology
	• Spinal pain in the presence of identifiable surgical target including:
	  ○ Radiologically demonstrable instability (e.g. spondylolisthesis)
	  ○ Pars Defect
	  ○ Infection

Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, severity, and duration of symptoms (e.g. pain, weakness, altered sensation, frequency, associated diseases) • Degree of functional impairment (e.g. walking distance, impact on employment/ADLs) • Current medication list • Any known allergies Examination • No defined criteria Investigations • Plain X-ray supporting diagnosis • For any lumbar spondylolisthesis– plain X-ray lateral standing films in flexion and extension NB: Imaging of the spine is not recommended in most patients with an acute presentation or with a stable chronic presentation unless there is the indication of sinister or serious pathology (**red flags**). If there are no signs of sinister or serious pathology, imaging may be indicated after a trial of conservative therapy. (Diagnostic Imaging Pathway)

Spine (Orthopaedics)	
	Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage. **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Details of previous treatment and outcome (e.g. analgesics, injections, allied health reports) • Other relevant reports from any providers in a public or private sector related to the presenting problem Examination • Clinical examination with respect to presenting symptoms Investigations • Imaging if indication of sinister or serious pathology • CT/MRI for suspected nerve pathology or any lumbar spondylolisthesis
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Stable spinal fractures without evolving neurological deficit
Category 2 Appointment within 90 days	Appropriate category 2 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist in consultation with the surgeon. • Any spinal cord compression with neurological signs/symptoms • Severe spinal disorders with significant functional impairment • Acute cervical & lumbar disc prolapse with moderate to severe radicular symptoms and stable neurological signs not responding to a minimum of 8 weeks of conservative management • Spondylolisthesis with lower limb neurology and/or instability on X-ray • Documented severe lumbar canal stenosis with significant neurogenic claudication/limitation of walking distance
Category 3 Appointment within 365 days	Appropriate category 3 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist in consultation with the surgeon. • Chronic cervical or lumbar disc prolapse and degenerative spinal disorders with stable neurological deficit

Exclusions for spine (Orthopaedics)	• Axial spine pain in the absence of identifiable surgical target. Referral to Pain Management should be considered.
	  ○ See Clinician Assist WA: Pain Management
	• Non-specific headache without red flags, concerning features or not requiring surgical intervention.
	  ○ See Clinician Assist WA: Non-acute Neurology Assessment

Spine (Orthopaedics)	

	• Spinal pain with systemic inflammatory disorder suggested by symptoms or blood tests.
	  ○ Refer to Rheumatology, see Clinician Assist WA: Rheumatology
	• Spinal cord and bony spinal tumours should be referred to Neurosurgery.
	  ○ See Clinician Assist WA: Neurosurgery Requests

Useful information for referring practitioners (non-exhaustive list)	• Any **acute** foot drop must be sent through to emergency for neurosurgical consultation.
	• Many acute spinal pain presentations may be appropriately managed in primary care. In the absence of red flags, these patients warrant a trial of conservative management for a minimum of 6-8 weeks. If there is no improvement, with ongoing neurological signs/symptoms after 8 weeks of conservative management, a referral to public outpatient specialist may be considered.
	• Appropriate category 2 and 3 patients may initially be assessed/re-assessed, and case managed by an advanced scope physiotherapist where available. These clinics are run alongside the consultant clinics and the surgeon is consulted on all cases. Outcomes may include provision of appropriate non-surgical management plans, appointment with a spinal surgeon, or discharge.
	• Due to resource limitations, there is significant wait times for category 2 and 3 patients.
	• Consider referral to pain management early as necessary.
	  ○ See Clinician Assist WA: Pain Management
	
	Conservative management
	• Initial 6-8 weeks of new onset sciatica in the absence of red flags warrants a trial of conservative management in primary care.
	• Caution should be used in prescribing opiates for spinal pain, which should be prescribed in line with current guidelines
	  ○ Anti-inflammatory and analgesia may be considered
	• Advice, education, and reassurance
	  ○ Heat, activity modification, normal activity
	• Consider physiotherapy and exercise.
	  ○ See Clinician Assist WA: Physiotherapy Requests
	• Radiculopathies and neural compressive symptoms secondary to spinal degeneration and deformity can be referred to the following specialities but will be triaged in a unified manner by all specialities concerned:
	  ○ Neurosurgery
	  ○ Orthopaedics
	
	Clinical resources
	• See Clinician Assist WA: Low Back Pain in Adults
	• See Clinician Assist WA: Pain Management
	• See ACSQHC LBP Clinical Care Standard (2022)
	• See ACSQHC Rapid Review Report: Diagnosis, Investigation and management of Low Back Pain (2020)
	• See Diagnostic Imaging Pathways

Delayed presentation trauma- Upper limb and lower limb

Referral to Emergency Department

If any of the following are present or suspected, please refer the patient to the emergency department (via ambulance if necessary) or seek emergency medical advice if in a remote region:

- Open fractures or fracture with obvious deformity
- Dislocations
- Tendon rupture
- Multi-ligament injuries
- Nail bed injuries or retained foreign body
- Neurovascular compromise
- Suspected septic joint

Immediately contact on-call registrar or service to arrange an immediate orthopaedic assessment (seen within 7 days):

- Acute closed fractures even with adequate alignment, except for acute closed metatarsal and toe fractures with adequate alignment, should be discussed with the on-call registrar
- Failed internal fixation

Clinical Indication for Outpatient Referral	• Deformity • Reduced ROM • Persisting pain • Difficulty weight bearing • Incomplete tendon rupture • Acute closed metatarsal and toe fractures with adequate alignment • High ankle sprains • Delayed union or mal-union of fracture
Mandatory Referral Information *Required for accurate and timely clinical triage* *Referral will be returned if information is not included*	History • Relevant history, onset, duration, and severity of symptoms (e.g. mechanism, pain, weakness, altered sensation) • Degree of functional impairment (e.g. engagement in high level sports, impact on employment/ADLs) • Current medication list • Any known allergies • Details of previous treatment and outcome (immobiliser, splint or cast etc.) Examination • No defined criteria Investigations • X-ray of relevant area– AP/lateral ○ For hand/wrist– consider scaphoid views, only if out of plaster **Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons). This information is required to inform accurate and timely triage.** **If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.**

Delayed presentation trauma- Upper limb and lower limb	
Highly Desirable Referral Information **The inclusion or exclusion of this information will not impact the referral being accepted.*	History • Injury on dominant or non-dominant hand • Details of other joint involvement Examination • Neurovascular examination Investigations • Ultrasound (US) if appropriate
Indicative Clinical Urgency Category *(wait times have been included to provide referrers with a guide as to how long their patient may need to wait for an outpatient appointment, these are intended as a guide only)*	
Category 1 Appointment within 30 days	• Acute closed metatarsal and toe fractures with adequate alignment • Functional disability or pain causing inability to cope at home
Category 2 Appointment within 90 days	• Delayed fracture union or non-union • Mal-union affecting function • Ankle injury with persisting pain >6 weeks • Ankle sprains unresponsive to maximal conservative management ≥3 months
Category 3 Appointment within 365 days	• Pain or disability persists despite maximal conservative management • Mild to moderate pain or functional deficit persists despite maximal conservative management
Exclusions for delayed presentation trauma- upper limb and lower limb	• Nil
Useful information for referring practitioners (non-exhaustive list)	• Please refer early as treatment may change with a delayed referral • Please note that where appropriate and available, the referral may be streamed to a fracture clinic, an advanced scope physiotherapy clinic and/or nursing practitioner service. This may include initial assessment and management by associated public allied health and/or nursing, which may either expedite or negate the need to see the public medical specialist.

Out of Scope / Excluded Procedures

The WA Elective Surgery Access and Waiting List Management Policy states that all elective procedures performed in the WA health system must meet an identified clinical need to improve the health of the patient. Procedures are not to be performed for cosmetic or other non-medical reasons.

Excluded Procedure	Exceptional circumstances
Aesthetic or cosmetic surgery	

Excluded procedures will not be performed unless under exceptional circumstances and where a clear clinical need has been identified. For all excluded procedure referrals, state clearly in the referral that request is for an excluded procedure and include the clinical exception reason as to why it should be considered.

The WA Elective Surgery Access and Waiting List Management Policy may be accessed via the WA Health Policy Frameworks page.

Referral to public Orthopaedics (Adult) outpatient services is not routinely accepted for the following conditions

Condition	Details
(Nil specialty level exclusions noted)	