NSW Health

Adult Orthopaedic State-wide Referral Criteria for Public Outpatient Services

This document is to be used as a guide for referrers and clinicians in NSW public outpatient services

The aim of SRC is to facilitate safe, timely and effective referral and prioritisation of patients requiring access to NSW public specialist outpatient services.

This document contains Orthopaedic SRC for orthopaedic emergencies, orthopaedic presentations out of scope, and the following presenting conditions:

- Orthopaedic emergencies
- Orthopaedic presentations out of scope
- Ankle or foot injury (acute) (adult)
- Ankle or foot osteoarthritis (adult)
- Back pain (adult)
- Hip osteoarthritis (adult)
- Knee osteoarthritis (adult)
- Knee pain (acute) (adult)
- Scoliosis or kyphosis (adult)
- Shoulder instability (adult)
- Shoulder pain (adult)
- Wrist or hand osteoarthritis (adult)
- Wrist or hand pain (adult)

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Notes

- Orthopaedic SRC sets thresholds for referral, regardless of source, to NSW public orthopaedic and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services, and the expected clinical urgency category based on clinical need
- Orthopaedic SRC supports patients to be managed by the most appropriate member(s) of the multidisciplinary care team in the most appropriate setting based on their presenting condition
- Orthopaedic SRC are applicable to NSW Local Health Districts and Specialty Health Networks with public orthopaedic and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services that manage the identified presenting conditions
- Orthopaedic SRC are applicable where the identified presenting conditions managed by orthopaedists are delivered in private practice as part of public-private hospital arrangements
- Orthopaedic SRC may also be used by a range of specialists in private practice at their own discretion
- Orthopaedic SRC does not intend to change eligibility in terms of presenting conditions managed and referral sources accepted for NSW public orthopaedic and applicable allied health-led, nurse-led, medical-led or surgical-led outpatient services
- Some NSW Local Health Districts and Specialty Health Networks may have different eligibility based on local contextual factors and/or service availability
- Referring health professionals may consider local alternative care options, including private practice, Aboriginal Community Controlled Health Services and/or non-government organisations, where appropriate, for patients seeking to access specialist services

Glossary

The structure for SRC in NSW is divided into the following five criterion.

In some cases, component(s) may not be applicable to each presenting condition. This will be denoted by ‘Nil’.

Criterion	Description
Emergency	• Clinical presentations or ‘red flags’ where referring health professionals should consider redirecting the patient to an Emergency Department or urgent care service, or seeking medical advice (e.g. phone on-call medical practitioner) • These criteria should not be used by referring health professionals to refer to an NSW public specialist outpatient service
Out of scope (not routinely provided)	• Symptoms, conditions and/or presentations that would not routinely be provided by NSW public specialist outpatient services (i.e. could be optimally and safely managed in primary care) • These criteria acknowledge and permit exceptions, where clinically appropriate
Access and prioritisation	• Symptoms, conditions and/or presentations that advise referring health professionals, clinicians, patients and carers suitability for management by NSW public specialist outpatient services • These criteria are classified by expected clinical urgency category and clinically recommended timeframes to be seen for a new outpatient appointment (i.e. Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days) • These criteria are only applicable where NSW public specialist outpatient services exist and manage the identified presenting condition
Required information	• Mandatory information that is to be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category
Additional information (if available)	• Optional information that can be supplied with referrals to NSW public specialist outpatient services for specific symptoms, conditions and/or presentations • These criteria support with the determination of an appropriate clinical urgency category, however, are not required to continue referral processing

Orthopaedic emergencies

Note: orthopaedic emergencies require immediate medical attention and/or intervention to prevent or manage serious harm to a patient. The list of emergency criteria below may not be exhaustive. Please refer to HealthPathways for more information.

Presenting condition	Emergency criteria
Ankle or foot injury (acute) (adult)	• Dislocations • Displaced ankle, midfoot, Lisfranc or hindfoot fracture (particularly talar and calcaneal fractures) • Nail bed trauma (subungual haematoma associated with distal phalanx fractures) • Open injuries with exposed tendons or bones/joints • Septic arthritis • Suspected neurovascular compromise or compartment syndrome • Syndesmosis injuries • Tendon ruptures
Ankle or foot osteoarthritis (adult)	• Pain following trauma where fracture is suspected • Suspected acute bone or joint infection Note: do not commence antibiotics until reviewed by specialist medical officer – contact on-call registrar to discuss clinical concerns • Suspected acute Charcot foot (where a High Risk Foot Service is not available) characterised by clinical signs of unilateral inflammation (redness, heat, swelling) present in the neuropathic foot, palpable pedal pulses, pain may be present despite neuropathy, no evidence of trauma, injury or ulcer to support infection

Back pain (adult)	• Atypical spinal pain with concern for vascular compromise or urgent non-musculoskeletal source of pain (e.g. ruptured or dissecting abdominal aortic aneurysm or other visceral pathology)
	• Spinal trauma or fracture
	• Sudden, progressive neurological signs or symptoms, including any of the following:
	  ○ Suspected Cauda equina syndrome (e.g. acute loss of bladder or bowel function due to suspected disc prolapse)
	  ○ Myelopathy in upper or lower extremities (e.g. heavy or weak legs and sudden change in gait, spasticity legs, hyperreflexia including upper motor neurone signs, weakness or clumsiness of hands)
	  ○ Rapidly progressive spinal nerve root compression (e.g. foot drop)

	• Suspected spinal infection (e.g. osteomyelitis, discitis, epidural abscess)
Hip osteoarthritis (adult)	• Fever (≥38°C), systemic symptoms and painful hip • Pain following trauma where fracture is suspected • Rapidly worsening symptoms • Sudden onset acute pain that is not improved by rest and/or pain so severe that weight bearing is not possible Note: consideration to be made to osteonecrosis, metastatic cancer, septic arthritis or fracture
Knee osteoarthritis (adult)	• Fever (≥38°C), systemic symptoms and painful swollen knee • Pain following trauma where fracture is suspected • Rapidly worsening symptoms • Sudden onset acute pain that is not improved by rest and/or pain so severe that weight bearing is not possible Note: consideration to be made to osteonecrosis, metastatic cancer, septic arthritis or fracture • Unable to differentiate an acute swollen knee from infection with serious pain
Knee pain (acute) (adult)	• Acute, multiple ligament knee injury (Grade 3 – complete) with uncontrolled pain and compromised mobility • Acute, post-surgical complications (e.g. bleeding, infection, wound breakdown) • Acute onset painful atraumatic knee effusion or haemarthrosis • Ruptured or severed tendons • Suspected acute bone or joint infection Note: do not commence antibiotics until reviewed by specialist medical officer. Contact on-call registrar to discuss clinical concerns. • Suspected fracture or dislocation
Scoliosis or kyphosis (adult)	• Malignancy with signs of spinal cord compression • New onset spinal pain or rapidly progressive neurological deficit (including bowel or bladder dysfunction) • Recent trauma with exacerbated symptoms of spinal pain or neurological change • Signs of infection in the presence of scoliotic or kyphotic deformity (e.g. high C-reactive protein, fever, malaise, sepsis)
Shoulder instability (adult)	• Acute traumatic shoulder dislocations, including unreduced or locked dislocations, and shoulder dislocations or pain following seizures or electrocution

	• Atypical shoulder pain that may be associated with chest pain or shortness of breath or stridor that could indicate cardiac or respiratory cause • Displaced or unstable fractures that cannot be managed in primary care • Signs of septic arthritis (local inflammation, pain, fever, and systemically unwell) • Signs of vascular injury or compromise • Unexplained mass or swelling
Shoulder pain (adult)	• Acute traumatic shoulder dislocations, including unreduced or locked dislocations, and shoulder dislocations or pain following seizures or electrocution • Atypical shoulder pain that may be associated with chest pain or shortness of breath or stridor that could indicate cardiac or respiratory cause • Fractures that cannot be managed in primary care • Signs of septic arthritis (local inflammation, pain, fever, and systemically unwell) • Signs of vascular injury or compromise • Sudden onset significant motor or sensory deficit in upper limb • Unexplained mass or swelling
Wrist or hand osteoarthritis (adult)	• Acute wrist trauma
Wrist or hand pain (adult)	• Acute wrist trauma • Septic arthritis of wrist or hand joints (suspected or confirmed)
Non-condition specific (adult)	• Acute back or neck pain secondary to neoplastic disease or infection • Acute cervical myelopathy • Acute development of peripheral nerve compression symptoms following trauma or acute event • Acute ligament rupture • Acute nerve injury • Acute onset painful atraumatic knee effusion or haemarthrosis • Compound ‘tooth knuckle’ injury • Crush injuries and suspected compartment syndrome (i.e. extreme pain with neurovascular compromise) • Evidence of acute inflammation (e.g. haemarthrosis, tense effusion) • Nail bed injuries or trauma (subungual haematoma associated with distal phalanx fractures) • Open injuries with exposed tendons, bones or joints • Retained foreign body • Ruptured or severed tendons • Significant lacerations

	• Signs of vascular injury or compromise • Sudden onset acute pain that is not improved by rest and/or pain so severe that weight bearing is not possible Note: consideration to be made to osteonecrosis, metastatic cancer, septic arthritis or fractur • Suspected acute bone or joint infection Note: do not commence antibiotics until reviewed by specialist medical officer, contact on-call registrar to discuss clinical concerns • Suspected infection or sudden pain in arthroplasty Note: if joint infection is suspected refer immediately to emergency or contact the orthopaedic registrar on call. Do not commence antibiotics unless delay to specialist review is likely. • Suspected neurovascular compromise or compartment syndrome • Suspected or known fractures with displacement or deformity requiring diagnosis, opinion or surgical treatment • Suspected or known joint dislocations unreduced or with neurovascular compromise requiring diagnosis, opinion or surgical treatment • Suspected or known septic arthritis or osteomyelitis • Syndesmosis injuries • Uncontrolled sepsis including hand infections • Upper limb radiculopathy in the presence of suspected cervical spine infection

Orthopaedic presentations out of scope

Presenting condition	Out of scope (not routinely provided) criteria
Ankle or foot injury (acute) (adult)	• Diabetic neuropathic conditions Note: consider referral to a High Risk Foot Service • Patients who would otherwise be referred to a Fracture clinic • Simple ankle sprain
Ankle or foot osteoarthritis (adult)	• Clinical symptoms not severe enough to require surgical opinion for intervention • Cosmetic foot surgery • Diabetic Charcot foot Note: consider to referral to a High Risk Foot Service • Osteoarthritis where non-operative management has not been undertaken • Patient already on surgical waitlist in another Local Health District for the same condition
Back pain (adult)	• Complex, persistent axial spinal back pain where surgical indications are not present Note: consider referral to a rheumatology or multidisciplinary pain service • Patient already on surgical waitlist in another Local Health District for the same condition • Spondyloarthropathies Note: consider referral to rheumatology • Uncomplicated fragility fractures of the axial spine
Hip osteoarthritis (adult)	• Clinical symptoms not severe enough to require surgical opinion for intervention • Osteoarthritis where non-operative management has not been undertaken • Patient already on surgical waitlist in another Local Health District for the same condition
Knee osteoarthritis (adult)	• Clinical symptoms not severe enough to require surgical opinion for intervention • Osteoarthritis where non-operative management has not been undertaken • Patient already on surgical waitlist in another Local Health District for the same condition • Uncomplicated inflammatory arthropathy (including crystal arthropathies) Note: consider referral to rheumatology
Knee pain (acute) (adult)	• Mild knee osteoarthritis or soreness • Uncomplicated degenerate meniscal tears • Uncomplicated inflammatory arthropathy (including crystal arthropathies) Note: consider referral to rheumatology

Scoliosis or kyphosis (adult)	• Intradural pathology based on MRI Note: consider referral to neurosurgery
Shoulder instability (adult)	• Patient already on a surgical waitlist in another Local Health District for the same condition
Shoulder pain (adult)	• Patient already on a surgical waitlist in another Local Health District for the same condition • Platelet-rich plasma (PRP) injections for shoulder pain, and repair of long head of biceps ruptures where primary concern is cosmesis • Rheumatological conditions (e.g. inflammatory arthritis, autoimmune connective tissue or muscle disorders, or osteoporosis without fracture)
Wrist or hand osteoarthritis (adult)	• Inflammatory arthropathy (including crystal arthropathies) Note: consider referral to rheumatology
Wrist or hand pain (adult)	• Patient who would otherwise be referred to a Fracture clinic • Uncomplicated inflammatory arthropathy (including crystal arthropathies) Note: consider referral to rheumatology
Non-condition specific (adult)	• Assessment prior to application for the Australian Defence Force, Police, NDIS, disability, pension, release of superannuation • Dupuytren's nodule without functional impairment or contracture • Non-specific headache without red flags concerning features or not requiring surgical intervention Note: consider referral to neurology • Patient already on surgical waitlist in another Local Health District for the same condition • Patient who would otherwise be referred to a Fracture clinic

Presenting conditions

Ankle or foot injury (acute) (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Dislocations
- Displaced ankle, midfoot, Lisfranc or hindfoot fracture (particularly talar and calcaneal fractures)
- Nail bed trauma (subungual haematoma associated with distal phalanx fractures)
- Open injuries with exposed tendons or bones/joints
- Septic arthritis
- Suspected neurovascular compromise or compartment syndrome
- Syndesmosis injuries
- Tendon ruptures

Out of scope (not routinely provided)

- Diabetic neuropathic conditions
  Note: consider referral to a High Risk Foot Service
- Patients who would otherwise be referred to a Fracture clinic
- Simple ankle sprain

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Stress fracture of the foot • Peroneal dislocation • Complex ankle sprain *Note: Consider assessment and treatment by physiotherapist prior to referral*
Category 2 (clinically recommended to be seen within 90 calendar days)	• Other neuropathic conditions affecting ankle or foot • Tendinopathies of the ankle or foot not responding to non-operative management *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (e.g. podiatry and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Recurrent ankle sprains (e.g. lateral ligament injuries) *Note: Patients are expected to have undertaken a trial of non-operative management (e.g. podiatry and physiotherapy, optimisation of health co-morbidities) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis

- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - X-ray of affected area and/or ultrasound if soft tissue (tendon) injury

Additional information (if available)

- Medical and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Ankle or foot osteoarthritis (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Pain following trauma where fracture is suspected
- Suspected acute bone or joint infection
  Note: do not commence antibiotics until reviewed by specialist medical officer – contact on-call registrar to discuss clinical concerns
- Suspected acute Charcot foot (where a High Risk Foot Service is not available) characterised by clinical signs of unilateral inflammation (redness, heat, swelling) present in the neuropathic foot, palpable pedal pulses, pain may be present despite neuropathy, no evidence of trauma, injury or ulcer to support infection

Out of scope (not routinely provided)

- Clinical symptoms not severe enough to require surgical opinion for intervention
- Cosmetic foot surgery
- Diabetic Charcot foot
  Note: consider referral to a High Risk Foot Service
- Osteoarthritis where non-operative management has not been undertaken
- Patient already on surgical waitlist in another Local Health District for the same condition

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Skin ulceration secondary to deformity or pressure • Acute collapse with symptoms associated with avascular necrosis or Charcot neuropathy (e.g. clinical signs of unilateral inflammation) • Severe bilateral joint disease • Severe difficulty in completing activities of daily living • Unexplained, severe ankle pain (e.g. possible malignancy, impending fracture) • Patient highly likely to present to an Emergency Department due to challenges with activities of daily living
Category 2 (clinically recommended to be seen within 90 calendar days)	• Non-acute ankle collapse associated with avascular necrosis, Charcot neuropathy or inflammatory arthritis • Rapid decline in function of ankle and foot • Persistent moderate ankle pain with gait disturbance that persists despite optimal non-surgical management (e.g. after 6 months of demonstrated supported exercise regime and weight loss attempt if indicated) • Inability to wear shoes *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (e.g. podiatry and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Stable osteoarthritis of foot and ankle with compensated function • Forefoot deformities with associated pain and/or osteoarthritis (e.g. bunions, claw toes)

	Note: Patients are expected to have undertaken a trial of non-operative management (e.g. podiatry and physiotherapy, optimisation of health co-morbidities) prior to referral

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)

Additional information (if available)

- Management to date (including use of immobilisation, splint or cast, corticosteroid injections, orthotics or insoles, podiatry or physiotherapy management)
- Previous surgery
- Evidence of significant impact on foot and ankle function, including mobility and falls risk
- Degree of interference with activities of daily living, walking tolerance and working ability
- Pain assessment (e.g. waking up at night, rest pain, analgesic consumption, aggravating and relieving factors)
- Functional range of motion
- Relevant pathology (e.g. Hb1Ac, albumin levels)
- X-ray: Ankle and foot – bilateral anterior to posterior (AP), lateral and oblique views (weight bearing)
- Medical (including vascular) and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Back pain (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Atypical spinal pain with concern for vascular compromise or urgent non-musculoskeletal source of pain (e.g. ruptured or dissecting abdominal aortic aneurysm or other visceral pathology)
- Spinal trauma or fracture
- Sudden, progressive or serious neurological signs or symptoms, including any of the following:
  - Suspected Cauda equina syndrome (e.g. acute loss of bladder or bowel function due to suspected disc prolapse)
  - Myelopathy in upper or lower extremities (e.g. heavy or weak legs and sudden change in gait, spasticity legs, hyperreflexia including upper motor neurone signs, weakness or clumsiness of hands)
  - Rapidly progressive spinal nerve root compression (e.g. foot drop)
- Suspected spinal infection (e.g. osteomyelitis, discitis, epidural abscess)

Out of scope (not routinely provided)

- Complex, persistent axial spinal back pain where surgical indications are not present
  Note: consider referral to a rheumatology or multidisciplinary pain service
- Patient already on surgical waitlist in another Local Health District for the same condition
- Spondyloarthropathies
  Note: consider referral to rheumatology
- Uncomplicated fragility fractures of the axial spine

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Risk of irreversible deficit if not seen within 1-4 weeks (e.g. foot drop) • Significant spinal nerve root compression or spinal cord compression with worsening neurological signs or symptoms (e.g. sudden, significant weakness or reflex changes) • Spinal tumours (benign or malignant) • Stable spinal fractures without worsening neurological deficit
Category 2 (clinically recommended to be seen within 90 calendar days)	• Severe back pain with significant functional impairment • Acute lumbar disc prolapse with moderate to severe radicular pain (with or without radiculopathy) *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Chronic primary back pain without progressive neurological deficit Note: consider referral to a rheumatology or multidisciplinary pain service

	• Documented severe lumbar canal stenosis with accompanying lower limb weakness, pain or paraesthesia impacting walking *Note: Patients are expected to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions)

Additional information (if available)

- Presence and duration of neurological signs and symptoms (highly desired)
- Presence of any of the following concerning features: (highly desired)
  - Age (at onset) < 16 or > 50 with new onset pain
  - Myotome weakness (include muscle group or action affected)
  - Recent significant trauma
  - Unexplained weight loss
  - Previous history of malignancy
  - Previous longstanding steroid use
  - History of IV drug use
  - Recent serious illness
  - Recent significant infection
- Mechanism of injury (highly desired)
- Functional status (highly desired)
- Management to date (including previous spinal surgery and non-operative management) (highly desired)
- Available, relevant pathology (highly desired)
  Note: consider inflammatory arthropathy, malignancy (primary or secondary) or myeloma prior to referral
- Relevant imaging results: X-ray or CT scan only where suspected sinister or serious pathology (concerning features)
- MRI result for suspected nerve pathology

Note: 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 (concerning features). If there are no signs of sinister or serious pathology imaging may be indicated after a trial of non-operative management.

- Medical and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Hip osteoarthritis (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Fever (≥38°C), systemic symptoms and painful hip
- Pain following trauma where fracture is suspected
- Rapidly worsening symptoms
- Sudden onset acute pain that is not improved by rest and/or pain so severe that weight bearing is not possible
  Note: consideration to be made to osteonecrosis, metastatic cancer, septic arthritis or fracture

Out of scope (not routinely provided)

- Clinical symptoms not severe enough to require surgical opinion for intervention
- Osteoarthritis where non-operative management has not been undertaken
- Patient already on surgical waitlist in another Local Health District for the same condition

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Severe bilateral joint disease • Severe hip pain causing difficulty in safely completing activities of daily living • Unexplained, severe hip pain (e.g. possible malignancy, impending fracture) • Patient highly likely to present to an Emergency Department due to challenges with activities of daily living
Category 2 (clinically recommended to be seen within 90 calendar days)	• Severe functional impairment that persists despite optimal non-surgical management (e.g. after 6 months of demonstrated supported exercise regime and weight loss attempt if indicated) • Severe hip osteoarthritis (as indicated by severe hip pain, night disturbance and/or limited mobility) *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Moderate hip osteoarthritis (as indicated by moderate hip pain, night disturbance and/or coping with symptoms) • Patient who require access to non-operative pathways Note: consider referral to an Osteoarthritis Chronic Care Program *Note: Patients are expected to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Evidence of significant impact on hip pain and function
    - Details of past non-operative management received
    - X-ray: Pelvis and hip – anterior to posterior (AP) views (within last 6 months of referral and weight bearing, where possible)

Additional information (if available)

- Medical and/or allied health reports
- Non-operative pathways that are unavailable
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Knee osteoarthritis (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Fever (≥ 38°C), systemic symptoms and painful swollen knee
- Pain following trauma where fracture is suspected
- Rapidly worsening symptoms
- Sudden onset acute pain that is not improved by rest and/or pain so severe that weight bearing is not possible
  Note: consideration to be made to osteonecrosis, metastatic cancer, septic arthritis or fracture
- Unable to differentiate an acute swollen knee from infection with serious pain

Out of scope (not routinely provided)

- Clinical symptoms not severe enough to require surgical opinion for intervention
- Osteoarthritis where non-operative management has not been undertaken
- Patient already on surgical waitlist in another Local Health District for the same condition
- Uncomplicated inflammatory arthropathy (including crystal arthropathies)
  Note: consider referral to rheumatology

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Severe bilateral knee osteoarthritis (as indicated by severe knee pain, night disturbance and/or limited mobility) • Severe difficulty in completing activities of daily living • Unexplained, severe knee pain (e.g. possible malignancy, impending fracture) • Patient highly likely to present to an Emergency Department due to challenges with activities of daily living
Category 2 (clinically recommended to be seen within 90 calendar days)	• Severe functional impairment that persists despite optimal non-surgical management (e.g. after 6 months of demonstrated supported exercise regime and weight loss attempt if indicated) • Severe unilateral knee osteoarthritis (as indicated by severe knee pain, night disturbance and/or limited mobility) *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (e.g. weight management, exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Patient who is unable to access non-operative pathways by alternative means Note: consider referral to an Osteoarthritis Chronic Care Program • Moderate knee osteoarthritis (as indicated by moderate knee pain, no night disturbance and/or coping with symptoms) *Note: Patients are expected to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Evidence of significant impact on knee pain and function
    - Details of past non-operative management received
    - X-ray: Knee series (including weight bearing and patella) within last 6 months of referral
      Note: consider referred pain to knee from hip or spine prior to referral

Additional information (if available)

- MRI result: Knee (if suspected locked knee or significant internal or ligamentous derangement)
- Medical and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Knee pain (acute) (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Acute, multiple ligament knee injury (Grade 3 – complete) with uncontrolled pain and compromised mobility
- Acute, post-surgical complications (e.g. bleeding, infection, wound breakdown)
- Acute onset painful atraumatic knee effusion or haemarthrosis
- Ruptured or severed tendons
- Suspected acute bone or joint infection
  Note: do not commence antibiotics until reviewed by specialist medical officer. Contact on-call registrar to discuss clinical concerns.
- Suspected fracture or dislocation

Out of scope (not routinely provided)

- Mild knee osteoarthritis or soreness
- Uncomplicated degenerate meniscal tears
- Uncomplicated inflammatory arthropathy (including crystal arthropathies)
  Note: consider referral to rheumatology

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Acute obstructed or locked knee (i.e. unable to reach full extension) • Acute, single ligament knee injury (Grade 2 or 3 – partial or complete) with functional knee instability • Acute, multiple ligament knee injury (any grade) with functional knee instability • Acute loss of full knee extension • Post-primary patella dislocation *Note: Consider assessment and treatment by physiotherapist prior to referral*
Category 2 (clinically recommended to be seen within 90 calendar days)	• Knee pain identified due to post-traumatic injury and/or effusion • Recurrent functional knee instability associated with suspected knee ligament injury • Patella instability • New onset knee pain in previous arthroplasty joint *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (including exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Meniscal injuries in the absence of locked knee • Functional impairment without knee instability and/or with knee pain persists despite maximal management

	Note: Patients are expected to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Management history including injury or trauma (if relevant), onset and duration, pain, associated features (e.g. swelling, instability), functional impairment and use of immobilisation, splint or cast
    - X-ray: Bilateral knees – anterior to posterior (AP), lateral and skyline views (weight bearing)

Additional information (if available)

- MRI result: Knee (if suspected locked knee, significant internal or ligamentous derangement)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Scoliosis or kyphosis (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Malignancy with signs of spinal cord compression
- New onset spinal pain or rapidly progressive neurological deficit (including bowel or bladder dysfunction)
- Recent trauma with exacerbated symptoms of spinal pain or neurological change
- Signs of infection in the presence of scoliotic or kyphotic deformity (e.g. high C-reactive protein, fever, malaise, sepsis)

Out of scope (not routinely provided)

- Intradural pathology based on MRI
  Note: consider referral to neurosurgery

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• New signs of neurological impairment (e.g. cervical or thoracic myelopathy)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Significant scoliosis in a young adult • Intractable spinal pain • Deformity with reduced lung function
Category 3 (clinically recommended to be seen within 365 calendar days)	• Degenerative scoliotic or kyphotic deformity *Note: Patients are expected to have undertaken a trial of non-operative management (e.g. exercise and physiotherapy, optimisation of health co-morbidities) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically X-ray (standing whole spine view)

Additional information (if available)

- MRI result of affected area
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Shoulder instability (adult)

Emergency
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 via phone to on-call consultant or registrar. • Acute traumatic shoulder dislocations, including unreduced or locked dislocations, and shoulder dislocations or pain following seizures or electrocution • Atypical shoulder pain that may be associated with chest pain or shortness of breath or stridor that could indicate cardiac or respiratory cause • Displaced or unstable fractures that cannot be managed in primary care • Signs of septic arthritis (local inflammation, pain, fever, and systemically unwell) • Signs of vascular injury or compromise • Unexplained mass or swelling
Out of scope (not routinely provided)
• Patient already on a surgical waitlist in another Local Health District for the same condition

Access and prioritisation	

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Primary acute shoulder dislocation (following emergency management)
	• Shoulder dislocation associated with any of the following:
	  ○ Rotator cuff pathology
	  ○ Fracture (excluding isolated Hills Sachs fracture)
	  ○ Signs of neurological injury
	  ○ Ongoing severe pain post reduction
	Note: Shoulder dislocations in patients who experience seizures need to have appropriate medical control of seizures for consideration of any surgical procedures for instability. Consider referral to a neurologist for seizure management prior to orthopaedic referral as appropriate.

Category 2
(clinically recommended to be seen within 90 calendar days)
	• History of previous traumatic primary shoulder dislocation and any of the following:
	  ○ Recurrent shoulder dislocation with low force mechanism
	  ○ Recurrent shoulder dislocation in a patient with higher-level work or sporting demands
	  ○ Recurrent shoulder dislocation and aged < 25 years
	Note: Patients are strongly encouraged to initiate non-operative management (e.g. physiotherapy including an exercise program) while awaiting orthopaedic review

Category 3 (clinically recommended to be seen within 365 calendar days)	• Recurrent dislocation in a person with lower-level work or functional demands with a history of previous traumatic primary dislocation • Chronic anterior shoulder instability • Chronic multidirectional shoulder instability

	Note: Patients are expected to have completed ≥ 6-month period of non-operative management (e.g. physiotherapy including an exercise program) prior to referral

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, mechanism, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Whether pain is related to trauma (if so, provide date of injury and mechanism)
  - Examination findings (including neurological examination where indicated)
  - X-ray: Shoulder – axillary, anterior to posterior (AP), lateral and Grashey (i.e. AP oblique internal rotation) views
  - Ultrasound: Shoulder (patients with suspected rotator cuff pathology only)

Additional information (if available)

- MRI result: Shoulder
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered 'at risk' or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Shoulder pain (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Acute traumatic shoulder dislocations, including unreduced or locked dislocations, and shoulder dislocations or pain following seizures or electrocution
- Atypical shoulder pain that may be associated with chest pain or shortness of breath or stridor that could indicate cardiac or respiratory cause
- Fractures that cannot be managed in primary care
- Signs of septic arthritis (local inflammation, pain, fever, and systemically unwell)
- Signs of vascular injury or compromise
- Sudden onset significant motor or sensory deficit in upper limb
- Unexplained mass or swelling

Out of scope (not routinely provided)

- Patient already on a surgical waitlist in another Local Health District for the same condition
- Platelet-rich plasma (PRP) injections for shoulder pain, and repair of long head of biceps ruptures where primary concern is cosmesis
- Rheumatological conditions (e.g. inflammatory arthritis, autoimmune connective tissue or muscle disorders, or osteoporosis without fracture)

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Confirmed or suspected malignancy in the shoulder • Aged < 70 years with acute traumatic full thickness rotator cuff tear and a significant loss of shoulder function • Severe glenohumeral osteoarthritis or rotator cuff arthropathy with severe pain and limitations affecting independence or likely to present to Emergency Department • Fractures that have had initial management in Emergency Department or primary care and need further management
Category 2 (clinically recommended to be seen within 90 calendar days)	• Traumatic partial thickness rotator cuff tear in surgically fit patient with ongoing shoulder pain • Atraumatic full thickness rotator cuff tears with significant shoulder impairment. • Severe glenohumeral osteoarthritis or rotator cuff arthropathy with severe pain and impact on activities of daily living • Unclear diagnosis or non-specific shoulder pain with significant impairment and impact on function seeking further management *Note: Patients are expected to have undergone ≥ 3-month period of non-operative management (including physiotherapy with an exercise program) and/or corticosteroid injection*

Category 3 (clinically recommended to be seen within 365 calendar days)	• Atraumatic rotator cuff related shoulder disorders (including partial thickness tears, tendinopathy and/or subacromial pain) • Moderate to severe glenohumeral or acromioclavicular joint osteoarthritis or rotator cuff arthropathy • Frozen shoulder in the stiff phase (i.e., stiff with minimal pain) with ongoing significant restriction in movement despite appropriate primary care management***** • Unclear diagnosis or non-specific shoulder pain seeking further management *Note: Patients are expected to have undergone ≥ 3-month period of non-operative management (e.g. physiotherapy including an exercise program) and/or corticosteroid injection* ****** Frozen shoulder should be suspected in patients 40-60 years of age with shoulder pain with or without metabolic risk factors. Criteria for diagnosis include reduced rotation range of motion ≤ 50% (especially external rotation) and normal X-ray. These patients should be managed in primary care with corticosteroid injection to the glenohumeral joint (not the subacromial bursa), or referral to rheumatology and/or physiotherapy and counselled regarding the appropriate timeframes for recovery.*

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Whether pain is related to trauma (if so, provide date of injury and mechanism)
    - Examination findings (including neurological examination where indicated)
    - X-ray: Shoulder – anterior to posterior (AP) and lateral views (patients with trauma or reduced range of motion only)
    - Ultrasound: Shoulder (patients with suspected rotator cuff pathology only)

Additional information (if available)

- MRI result: Shoulder
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Wrist or hand osteoarthritis (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Acute wrist trauma

Out of scope (not routinely provided)

- Inflammatory arthropathy (including crystal arthropathies)
  Note: consider referral to rheumatology

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Wrist or hand pain resulting in rapid deterioration in function • History of trauma to wrist or hand (i.e. missed fracture) • Severe nerve compression of the hand (e.g. carpal tunnel syndrome)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Sudden onset pain in wrist or hand < 3 months • Chronic deformity of the wrist or hand affecting activities of daily living • Severe 1st carpometacarpal osteoarthritis • Ganglion, trigger finger or trigger thumb *Note: Patients are strongly encouraged to have undertaken a trial of non-operative management (including hand therapy) prior to referral*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Painful or stiff wrist or hand for ≥ 3 months • Moderate 1st carpometacarpal osteoarthritis *Note: Patients are expected to have undertaken a trial of non-operative management (including hand therapy) prior to referral*

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Fall or trauma history
  - Functional assessment (including range of motion)
  - X-ray: Anterior to posterior (AP) and lateral wrist (consider scaphoid) views

Additional information (if available)

- Relevant pathology
  Note: consider inflammatory arthropathy prior to referral
- Management to date
- Medical and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)

Wrist or hand pain (adult)

Emergency

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 via phone to on-call consultant or registrar.

- Acute wrist trauma
- Septic arthritis of wrist or hand joints (suspected or confirmed)

Out of scope (not routinely provided)

- Patient who would otherwise be referred to a Fracture clinic
- Uncomplicated inflammatory arthropathy (including crystal arthropathies)
  Note: consider referral to rheumatology

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Wrist or hand pain resulting in rapid deterioration in function • History of trauma to wrist or hand (i.e. missed fracture) • Severe nerve compression of the hand (e.g. carpal tunnel syndrome) *Note: Antenatal in 3rd trimester or post-partum ≤ 6 months with carpal tunnel syndrome should be referred to hand therapy in the first instance. Patient to be escalated to hand or orthopaedic service if this management fails.*
Category 2 (clinically recommended to be seen within 90 calendar days)	• Sudden onset pain in wrist or hand < 3 months
Category 3 (clinically recommended to be seen within 365 calendar days)	• Painful or stiff wrist or hand for ≥ 3 months

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, severity, location of pain and impact on function
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Fall or trauma history
  - Functional assessment (including range of motion)
  - X-ray: Anterior to posterior (AP) and lateral wrist (consider scaphoid) views (where appropriate)
  - Nerve conduction study (as appropriate and where possible)

Additional information (if available)

- Relevant pathology
- Management to date
- Medical and/or allied health reports
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ or among a vulnerable, disadvantaged or priority population
- If the patient is willing to have surgery (where clinically relevant)
- If the patient is suitable for virtual care or telehealth
- If the patient has special needs or requires reasonable adjustments to be made
- If the patient requires an interpreter (if so, list preferred language)