NSW Health

Paediatric 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
- Back pain (paediatric)
- Baker's cyst (paediatric)
- Bow legs (paediatric)
- Club foot (paediatric)
- Curly toes (paediatric)
- Developmental hip dysplasia (paediatric)
- Flat feet (paediatric)
- In-toeing (paediatric)
- Knee injury (paediatric)
- Knock knees (paediatric)
- Limp (paediatric)
- Metatarsus adductus (paediatric)
- Out-toeing (paediatric)
- Perthes disease (paediatric)
- Scoliosis or kyphosis (paediatric)
- Slipped upper femoral epiphysis (paediatric)
- Toe walking (paediatric)

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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

Back pain (paediatric)	• Back pain with any of the following red flags:
	  ○ Acute onset (< 6 weeks)
	  ○ Bowel or bladder dysfunction
	  ○ Fever
	  ○ Neurological deficit
	  ○ Severe pain
	  ○ Trauma

Baker's cyst (paediatric)	• Febrile or systemically unwell
Bow legs (paediatric)	• Abnormal calcium levels • Fracture
Club foot (paediatric)	• Nil emergency criteria
Curly toes (paediatric)	• Nil emergency criteria
Developmental hip dysplasia (paediatric)	• Suspected septic arthritis of the hip
Flat feet (paediatric)	• Nil emergency criteria
In-toeing (paediatric)	• Acute joint pain with restricted range of motion • Acute onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving • Suspected fracture • Suspected septic arthritis
Knee injury (paediatric)	• Acute patella dislocation or unreduced subluxation • Fracture • Haemarthrosis • Lacerations or penetrating wound into the knee requiring acute management • Locked knee • Neurovascular injury • Suspected patella or quadriceps tendon rupture • Systemically unwell
Knock knees (paediatric)	• Suspected fracture
Limp (paediatric)	• Acute onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving • New diagnosis of Slipped Upper Femoral Epiphysis (SUFE)

	• Suspected bony or limb soft tissue malignancy • Suspected fracture • Suspected septic arthritis or osteomyelitis • Suspected non-accidental injury
Metatarsus adductus (paediatric)	• Nil emergency criteria
Out-toeing (paediatric)	• New diagnosis of Slipped Upper Femoral Epiphysis (SUFE) • Suspected fracture Note: Pelvic x-rays: anterior to posterior (AP) and frog leg lateral views) are required for all children aged > 10 years presenting with out-toeing
Perthes disease (paediatric)	• Acute hip joint pain with restricted range of motion • Acute onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving • Suspected septic arthritis or osteomyelitis
Scoliosis or kyphosis (paediatric)	• Acute breathlessness in the context of bony thoracic trauma • Back pain with any of the following red flags: o Acute onset (< 6 weeks) o Bowel or bladder dysfunction o Fever o Neurological deficit o Severe pain o Trauma • Scoliosis or kyphosis associated with orthopaedic trauma Scoliosis or kyphosis with abnormal neurological exam
Slipped upper femoral epiphysis (paediatric)	• New diagnosis of Slipped Upper Femoral Epiphysis (SUFE) Note: all patients with SUFE require referral to the emergency department or direct contact with the local orthopaedic service. Patient should be advised to be non-weight bearing – using crutches (where practical) or a wheelchair, even when mild or stable due to the risk of progression. If completely unable to weight bear, urgent transfer by ambulance is required.
Toe walking (paediatric)	• Nil emergency criteria
Non-condition specific (paediatric)	• Abnormal neurological exam in the context of orthopaedic trauma, limb neurology or injury with neurovascular compromise • Acute joint pain with restricted range of motion • Lacerations or penetrating wound requiring acute management Note: in children, a higher index of suspicion for underlying neurovascular and tendinous injury • Suspected bony or limb soft tissue malignancy

	• Suspected fractures or dislocations with displacement or deformity • Suspected ligament or tendon rupture • Suspected non-accidental injury • Suspected septic arthritis or osteomyelitis

Orthopaedic presentations out of scope

Presenting condition	Out of scope (not routinely provided) criteria
Back pain (paediatric)	• Nil out of scope criteria
Baker's cyst (paediatric)	• Solid mass on ultrasound Note: consider diagnoses other than Baker's cyst (e.g. tumour) and refer to most appropriate speciality
Bow legs (paediatric)	• Bow legs and aged < 1 year old (in an otherwise normal child)
Club foot (paediatric)	• Nil out of scope criteria
Curly toes (paediatric)	• Curly toes and child aged < 3 years • Other structural abnormalities (e.g. webbing)
Developmental hip dysplasia (paediatric)	• Asymmetric skin creases with normal imaging • Risk factors for developmental hip dysplasia with normal imaging (see 'Required information' for imaging guidelines)
Flat feet (paediatric)	• Child aged < 8 years with functional impairment (e.g. recurrent falls) as a result of flat foot Note: consider referral to physiotherapy • Flexible flat foot (i.e. arch reconstitutes on heel raise) without pain
In-toeing (paediatric)	• Child with in-toeing who has been walking for < 6 months
Knee injury (paediatric)	• Chronic recurrent multifocal osteomyelitis (also known as non-bacterial osteitis) Note: consider referral to rheumatology • Jumper's knee Note: consider referral to sports medicine or physiotherapy • Non-traumatic knee pain with no diagnosis in the presence of normal hip and knee imaging Note: consider referral to sports medicine or physiotherapy. Consider referred pain from the hip and hip X-rays. • Non-traumatic monoarticular swelling with no structural damage on MRI Note: consider referral to rheumatology • Osgood-Schlatter disease Note: consider referral to sports medicine or physiotherapy • Suspected inflammatory diagnosis (e.g. juvenile idiopathic arthritis, juvenile rheumatoid arthritis) Note: consider referral to rheumatology
Knock knees (paediatric)	• Nil out of scope criteria Note: typically children aged 3-4 years have knock knee alignment that improves over time. Reassurance at this age is recommended.

Limp (paediatric)	• Nil out of scope criteria
Metatarsus adductus (paediatric)	• Nil out of scope criteria
Out-toeing (paediatric)	• Out-toeing and aged < 2 years (in otherwise normal child)
Perthes disease (paediatric)	• Nil out of scope criteria
Scoliosis or kyphosis (paediatric)	• Kyphosis < 50 degrees in a skeletally mature child without pain • Scoliosis < 10 degrees in a skeletally mature child without pain
Slipped upper femoral epiphysis (paediatric)	• Nil out of scope criteria
Toe walking (paediatric)	• Toe walking with full passive ankle range of motion
Non-condition specific (paediatric)	• Assessment prior to application for disability • Ingrown toenail

Presenting conditions

Back pain (paediatric)

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.

- Back pain with any of the following red flags:
  - Acute onset (< 6 weeks)
  - Bowel or bladder dysfunction
  - Fever
  - Neurological deficit
  - Severe pain
  - Trauma

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Back pain associated with spondylolisthesis and normal neurology • Radiculopathy beyond 6 weeks where other treatments have proved unsuccessful

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Back pain associated with any of the following:
	  ○ Scoliosis
	  ○ Kyphosis
	• Persistent back pain with no red flags
	Note: red flags are listed in the 'Emergency' criteria

Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition, including evolution of symptoms and their duration
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Neurological signs (if abnormal, consider redirection to emergency)
  - Treatment prescribed (analgesics, physiotherapy)
  - Relevant family history (e.g. scoliosis)
  - X-ray: Erect whole spine (or EOS) - anterior to posterior (AP) and lateral views

Additional information (if available)

- MRI result of affected area
- Other investigations (if performed)
- 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 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)

Baker's cyst (paediatric)

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.

- Febrile or systemically unwell

Out of scope (not routinely provided)

- Solid mass on ultrasound
  Note: consider diagnoses other than Baker's cyst (e.g. tumour) and refer to most appropriate specialty

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil
Category 3 (clinically recommended to be seen within 365 calendar days)	• Confirmed Baker's cyst on ultrasound *Note: The treatment of Baker's cyst is almost always non-operative. Management largely consists of provision of education to the family, even when symptomatic.*

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 ultrasound (knee)

Additional information (if available)

- 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 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)

Bow legs (paediatric)

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.

- Abnormal calcium levels
- Fracture

Out of scope (not routinely provided)

- Bow legs and aged < 1 year old (in an otherwise normal child)

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil

Category 2
(clinically recommended to be seen within 90 calendar days)
	• Bow legs with any of the following:
	  ○ Chronic illness (e.g. renal disease, rickets, prolonged steroid use)
	  ○ Severe or progressive bowing (i.e. intercondylar distance in standing > 6 cm)
	  ○ Unilateral deformity
	  ○ Height below 3rd percentile
	• Multiple joint involvement or other skeletal deformities
	• New onset bow legs in child aged ≥ 3 years
	• Bow legs following healed fracture

Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition, including evolution of symptoms and their duration, and associated complaints (onset, progression)
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - History of infection, trauma and fracture
  - Treatment prescribed and efficacy
  - Relevant family history
  - Risk factor for rickets
  - Growth parameters
  - Observation of gait
  - X-ray: Weight bearing bilateral long leg (if unilateral deformity, progressive deformity, lack of spontaneous resolution and/or aged > 3 years)

Additional information (if available)

- Dietary and vitamin intake
- Relevant pathology (e.g. calcium, magnesium, phosphate, corrected calcium, albumin, parathyroid hormone, vitamin D levels (if severe bowing))
- 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 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)

Club foot (paediatric)

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.

- Nil

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Newly diagnosed, structural club foot
Category 2 (clinically recommended to be seen within 90 calendar days)	• Positional talipes or metatarsus adductus not responding to physiotherapy treatment • Recurrent club foot affecting ambulation
Category 3 (clinically recommended to be seen within 365 calendar days)	• Recurrent club foot not affecting ambulation

Required information

- Reason for referral
- Details of the presenting condition, including evolution of symptoms and their duration
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically passively correctable or positional club foot

Additional information (if available)

- 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 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)

Curly toes (paediatric)

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.

- Nil

Out of scope (not routinely provided)

- Curly toes and child aged < 3 years
- Other structural abnormalities (e.g. webbing)

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil

Category 3
(clinically recommended to be seen within 365 calendar days)
	• Curly toes and any of the following:
	  ○ Child aged ≥ 3 years
	  ○ Calluses
	  ○ Pain
	  ○ Footwear problems (e.g. blisters or pressure areas develop as the result of wearing shoes)

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 family history of curly toes

Additional information (if available)

- 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 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)

Developmental hip dysplasia (paediatric)

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.

- Suspected septic arthritis of the hip

Out of scope (not routinely provided)

- Asymmetric skin creases with normal imaging
- Risk factors for developmental hip dysplasia with normal imaging (see 'Required information' for imaging guidelines)

Access and prioritisation

Category 1
(clinically recommended to be seen within 30 calendar days)
	• Dislocated or subluxed developmental hip dysplasia on imaging, regardless of age
	• Severe hip dysplasia on ultrasound or X-ray, regardless of age
	• Persistent hip dysplasia on ultrasound (i.e. femoral head coverage of < 50%) at 3-6 months of age
	• Abnormal clinical examination based on any of the following:
	  ○ Positive Ortolani's or Barlow's test
	  ○ Limited hip abduction
	  ○ Leg length discrepancy
	
	Note: Abnormal clinical signs warrant imaging prior to referral

Category 2 (clinically recommended to be seen within 90 calendar days)	• Mild or moderate hip dysplasia on X-ray in child aged 6-24 months • Adolescents with hip pain and underlying developmental hip dysplasia
Category 3 (clinically recommended to be seen within 365 calendar days)	• Mild or moderate hip dysplasia on X-ray in child aged ≥ 2 years

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:
  - Indication for screening
  - Risk factors for developmental hip dysplasia
  - Treatment prescribed (e.g. physiotherapy, orthotic bracing)
  - Relevant family history
  - Ultrasound: Hips (if child aged < 6 months)

- X-ray: Hips (if child aged ≥ 6 months)

Note: If any uncertainty on early ultrasounds, a 6-month X-ray and consideration for referral as per above guidelines is recommended

Additional information (if available)

- 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 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)

Flat feet (paediatric)

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.

- Nil

Out of scope (not routinely provided)

- Child aged < 8 years with functional impairment (e.g. recurrent falls) as a result of flat foot
  Note: consider referral to physiotherapy
- Flexible flat foot (i.e. arch reconstitutes on heel raise) without pain

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Symptomatic flat foot (e.g. pain, limp, stiffness) • Unilateral flat foot • Child aged ≥ 8 years with functional impairment as a result of flat foot
Category 3 (clinically recommended to be seen within 365 calendar days)	• Ongoing concerns in a child aged < 8 years with functional impairment as a result of flat foot despite physiotherapy and parental reassurance

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration
- 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: Feet – Weight bearing – anterior to posterior (AP), lateral and oblique views

Additional information (if available)

- 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 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)

In-toeing (paediatric)

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 joint pain with restricted range of motion
- Acute onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving
- Suspected fracture
- Suspected septic arthritis

Out of scope (not routinely provided)

- Child with in-toeing who has been walking for < 6 months

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Nil

Category 3
(clinically recommended to be seen within 365 calendar days)
	• In-toeing with any of the following:
	  ○ Unilateral
	  ○ Severe
	  ○ Causing tripping in a school-age child
	  ○ Residual in-toeing in child aged ≥ 10 years
	• Symptomatic in-toeing with functional impairment
	• Cosmetic concern to the patient and family for a child aged ≥ 12 years
	Note: it is very unlikely that any treatment will be required

Required information

- Reason for referral
- Details of the presenting condition, including symptoms and their duration, nature of pain, impairment and functional impact
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Treatment prescribed (physiotherapy, orthotics)
  - Relevant family history (e.g. persistent in-toeing)

Additional information (if available)

- 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 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 injury (paediatric)

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 patella dislocation or unreduced subluxation
- Fracture
- Haemarthrosis
- Lacerations or penetrating wound into the knee requiring acute management
- Locked knee
- Neurovascular injury
- Suspected patella or quadriceps tendon rupture
- Systemically unwell

Out of scope (not routinely provided)

- Chronic recurrent multifocal osteomyelitis (also known as non-bacterial osteitis)
  Note: consider referral to rheumatology
- Jumper's knee
  Note: consider referral to sports medicine or physiotherapy
- Non-traumatic knee pain with no diagnosis in the presence of normal hip and knee imaging
  Note: consider referral to sports medicine or physiotherapy. Consider referred pain from the hip and hip X-rays.
- Non-traumatic monoarticular swelling with no structural damage on MRI
  Note: consider referral to rheumatology
- Osgood-Schlatter disease
  Note: consider referral to sports medicine or physiotherapy
- Suspected inflammatory diagnosis (e.g. juvenile idiopathic arthritis, juvenile rheumatoid arthritis)
  Note: consider referral to rheumatology

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Meniscal tear (including bucket handle) • Acute osteochondral fracture • Anterior cruciate ligament (ACL) injury • Other ligamentous injury (including posterior cruciate ligament, medial collateral ligament and lateral collateral ligament)
Category 2 (clinically recommended to be seen within 90 calendar days)	• Degenerative or traumatic cartilage pathology (e.g. osteochondritis dissecans) • Post-traumatic limb deformity • Loose body in knee • Recurrent patella instability • Intermittent locking episodes Note: consider MRI prior to referral
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition, including nature of symptoms (e.g. pain, swelling, instability, locking, deformity) and date of injury
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Response to other treatments (e.g. physiotherapy)
    - X-ray: Knee – anterior to posterior (AP), lateral and skyline views of the affected knee

Additional information (if available)

- MRI result: Knee
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)

Knock knees (paediatric)

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.

- Suspected fracture

Out of scope (not routinely provided)

- Nil

Note: typically children aged 3-4 years have knock knee alignment that improves over time. Reassurance at this age is recommended.

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Progressive knock knees following a fracture or infection • Asymmetrical or progressive deformity
Category 3 (clinically recommended to be seen within 365 calendar days)	• Persistent knock knees in a child aged ≥ 8 years (i.e. intermalleolar standing distance > 8 cm) • Knock knees with functional impairment in a child aged ≥ 8 years • Knock knees associated with other skeletal deformities • Stature below the 3rd percentile and has already seen another specialist to exclude metabolic disease

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Treatment prescribed (e.g. physiotherapy)
  - Relevant family history
  - X-ray: Weight bearing long leg (if unilateral, severe, or progressive deformity and > 8 years of age)

Additional information (if available)

- Photograph of the legs
  Note: clinical photographs can be very helpful at monitoring progress and review after 6-12 months. Photographs alone can avoid the need for specialist referral.
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

- 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)

Limp (paediatric)

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 onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving
- New diagnosis of Slipped Upper Femoral Epiphysis (SUFE)
- Suspected bony or limb soft tissue malignancy
- Suspected fracture
- Suspected septic arthritis or osteomyelitis
- Suspected non-accidental injury

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Suspected developmental hip dysplasia Note: refer to state-wide referral criteria for developmental hip dysplasia • Suspected Perthes disease Note: refer to state-wide referral criteria for Perthes disease
Category 2 (clinically recommended to be seen within 90 calendar days)	• Persistent limp > 3 months with normal X-rays (e.g. hip or localised area)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Assessment of gait
    - Treatment prescribed (analgesics, physiotherapy)
    - Relevant family history (e.g. rheumatological conditions)
    - Relevant pathology (e.g. full blood count (FBC), C-reactive protein (CRP), erythrocyte sedimentation rate (ESR))
    - X-ray: Pelvis - anterior to posterior (AP) and frog leg lateral views
    - Ultrasound: (e.g. hip) (where appropriate)

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)

Metatarsus adductus (paediatric)

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.

- Nil

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Structural Congenital Talipes Equinovarus (CTEV) Note: refer to state-wide referral criteria for club foot • Rigid foot deformity
Category 2 (clinically recommended to be seen within 90 calendar days)	• Flexible foot deformity not responding to physiotherapy or stretches in early infancy (e.g. by 6 months of age)
Category 3 (clinically recommended to be seen within 365 calendar days)	• Child aged > 2 years with significant metatarsus adductus causing functional problems or difficulty with footwear

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:
  - Presence of flexible and/or rigid deformity
  - Prior treatment (e.g. physiotherapy or stretches)
  - Family history of residual metatarsus adductus or foot conditions
  - Hip screening tests (e.g. Barlow and Ortolani tests)

Additional information (if available)

- Hip imaging (e.g. ultrasound in child aged < 6 months, X-ray in child aged ≥ 6 months)
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)

Out-toeing (paediatric)

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.

- New diagnosis of Slipped Upper Femoral Epiphysis (SUFE)
- Suspected fracture

Note: Pelvic x-rays: anterior to posterior (AP) and frog leg lateral views) are required for all children aged > 10 years presenting with out-toeing

Out of scope (not routinely provided)

- Out-toeing and aged < 2 years (in otherwise normal child)

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Nil
Category 2 (clinically recommended to be seen within 90 calendar days)	• Out-toeing with pain Note: consider fracture as a diagnosis
Category 3 (clinically recommended to be seen within 365 calendar days)	• Out-toeing with any of the following: ○ Unilateral deformity ○ Persistent or progressive deformity ○ Functional difficulties (excluding infants) ○ Thigh-foot angle > 30-40 degrees external

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Assessment of gait
  - Treatment prescribed (analgesics, physiotherapy)
  - Relevant family history
  - X-ray: Pelvis - anterior to posterior (AP) and frog leg lateral views (if asymmetrical deformity or acute onset)

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)

Perthes disease (paediatric)

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 hip joint pain with restricted range of motion
- Acute onset limp with signs of being unwell, fever, joint irritability, not weight bearing and/or not improving
- Suspected septic arthritis or osteomyelitis

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Confirmed or suspected Perthes disease
Category 2 (clinically recommended to be seen within 90 calendar days)	• Known Perthes disease with a current treatment plan
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Treatment prescribed (e.g. analgesics, physiotherapy)
    - Relevant family history
    - X-ray: Pelvis - anterior to posterior (AP) and frog leg lateral views

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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 (paediatric)

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 breathlessness in the context of bony thoracic trauma
- Back pain with any of the following red flags:
  - Acute onset (< 6 weeks)
  - Bowel or bladder dysfunction
  - Fever
  - Neurological deficit
  - Severe pain
  - Trauma
- Scoliosis or kyphosis associated with trauma
  Scoliosis or kyphosis with abnormal neurological exam

Out of scope (not routinely provided)

- Kyphosis < 50 degrees in a skeletally mature child without pain
- Scoliosis < 10 degrees in a skeletally mature child without pain

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Kyphosis with pain • Scoliosis with pain
Category 2 (clinically recommended to be seen within 90 calendar days)	• Kyphosis confirmed on X-ray ≥ 50 degrees without pain • Scoliosis confirmed on X-ray ≥ 10 degrees without pain
Category 3 (clinically recommended to be seen within 365 calendar days)	• Second opinion for a child with confirmed scoliosis or kyphosis with a current treatment plan

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
  - Treatment prescribed
  - Relevant family history
  - Other diseases associated with scoliosis, kyphosis or neurological deficits
  - X-ray: Erect whole spine (or EOS) confirming scoliosis or kyphosis

Additional information (if available)

- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population

Slipped upper femoral epiphysis (paediatric)

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.

- New diagnosis of Slipped Upper Femoral Epiphysis (SUFE)

Note: all patients with SUFE require referral to the emergency department or direct contact with the local orthopaedic service. Patient should be advised to be non-weight bearing – using crutches (where practical) or a wheelchair, even when mild or stable due to the risk of progression. If completely unable to weight bear, urgent transfer by ambulance is required.

Out of scope (not routinely provided)

- Nil

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• New onset pain or disability following treatment in a patient with confirmed Slipped Upper Femoral Epiphysis (SUFE) *Note: If pain is severe, contact treating surgical team*
Category 2 (clinically recommended to be seen within 90 calendar days)	• New onset pain or disability in a patient with confirmed SUFE with a current treatment plan
Category 3 (clinically recommended to be seen within 365 calendar days)	• Nil

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Treatment prescribed
    - Relevant family history
    - X-ray: Pelvis - anterior to posterior (AP) and frog leg lateral views of both hips

Additional information (if available)

- Prior history of SUFE
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)

Toe walking (paediatric)

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.

- Nil

Out of scope (not routinely provided)

- Toe walking with full passive ankle range of motion

Access and prioritisation

Category 1 (clinically recommended to be seen within 30 calendar days)	• Acute toe walking • Abnormal spinal examination
Category 2 (clinically recommended to be seen within 90 calendar days)	• Unilateral toe walking *Note: If unilateral toe walking, obtain pelvic X-rays to assess for developmental hip dysplasia*
Category 3 (clinically recommended to be seen within 365 calendar days)	• Persistent toe walking in a school-aged child despite physiotherapy • Unable to dorsiflex feet beyond neutral, stand with heels down or walk on heels • Signs of cerebral palsy with hypertonia, hyperreflexia or ataxia • Calf hypertrophy • Toe walking associated with developmental delay *Note: Patients with associated developmental delay or suspected hypotonia or cerebral palsy should also be referred to a general paediatrician if not already under paediatric care*

Required information

- Reason for referral
- Details of the presenting condition including evolution and duration of symptoms
- Provisional diagnosis
- Patient health summary (such as relevant medical history, relevant investigations, current medications and dosages, immunisations, allergies and/or adverse reactions), including specifically:
    - Treatment prescribed (e.g. physiotherapy, casting, splints)
    - Relevant family history (i.e. hereditary neurological condition)
    - Neurological examination

Additional information (if available)

- Creatine phosphokinase (CPK) level
- If the patient identifies as Aboriginal and/or Torres Strait Islander
- If the patient is considered ‘at risk’ and/or among a vulnerable, disadvantaged or priority population
- 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)