|  |  |
| --- | --- |
| **Patient Consent Given\*:** | YES |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** |  | **Referrer Details** |  |
| Surname: |  | Referring GP: |  |
| Forename: |  | Usual GP: |  |
| Address: |  | Address: |  |
| Home tel: |  | Tel: |  |
| Mobile tel: |  | Email: |  |
| Date of Birth: |  | Referral Date: |  |
| NHS Number: |  | **Interpreter Required:** |  |
| **Preferred Language\*:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Speciality\*:** |  | | **Clinic\*:** | |  | |
| **Referral Status\*:** | Routine |  | Urgent |  | | **Intended Place of Referral\*: ACUTE** |

**Primary KNEE Replacement Surgery**

**Referral Criteria (Please select):**

**Guidance**

**1. Patients shall be eligible for surgery if the following criteria is met in either Section** **A B or C**:

**Section A**

Patients shall be eligible for surgery if ALL of the following criteria are met:

The patient has been referred to and managed by a musculoskeletal (MSK) service 

**AND**

The patient has a BMI below 35 

**AND**

Please confirm that the patient is supported by a primary care and/or community service referral 

**AND**

Please confirm that conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have been exhausted and failed to alleviate the patient’s pain and disability 

**AND**

Please confirm that the patient’s pain and disability is sufficiently significant to interfere with the patients’ daily life and or ability to sleep 

**AND**

Please confirm that the patient accepts and wants surgery 

All boxes in section A need to be ticked to meet the criteria for referral

**Section B**

1. **Patient has a BMI of 35 or over** **but mobility is so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat**  
2. **Loss of Independence** - **Unable to maintain activities of daily living** 

|  |  |  |  |
| --- | --- | --- | --- |
| **Activities of Daily Living** | **Requires Assistance** | **Not Applicable** | |
| Dressing |  |  | |
| Walking |  |  | |
| Transferring from Chair |  |  | |
| Bathing |  |  | |
| Climbing Stairs |  |  | |
| Driving |  |  | |
| ***Activities of daily living- 4 out of 6 needed to require assistance*** | | | One part in section B needs to be ticked to meet the criteria for referral |

The loss of Independence table needs to be completed if Section 2 has been selected

**Section C**

Patient has a BMI of 35 or over but the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure (Recent x-ray report required) 

**If the patient does not meet any of the above criteria and has a BMI of 35 or over:** 

*If the patient does not meet any of the above criteria and has a BMI of 35 or over they will be referred by their GP to weight management services and will be expected to engage with the services to achieve the required BMI.*

*Should the patient’s BMI fall below 35 then the patient would be eligible for surgery in line with the policy criteria.*

***If this weight loss cannot be achieved the patient will be eligible for referral for surgery from two years after the documented date of the GP referral to weight management services for the purpose of weight loss prior to surgery****.*

Please attach any relevant tests, investigations or clinic letters.

One box in section 3 needs to be ticked to meet the criteria for referral

|  |  |
| --- | --- |
| **2**. **CONSENT FOR REFERRAL**  Please confirm that the patient (or responsible carer) consented to specialist referral | |
| **3.** **CLINICIAN DECLARATION**   I personally confirm that the above information is complete and accurately describes the patient's condition   \* Required  **Note: Treatment should only be undertaken in secondary care if this form is approved.**\* Required\* Consider if an IFR form is appropriate for this patient? Do not proceed with this application. | |
| **Allergies:** | |
|  |  |
| **Current Medication:** | |
|  |  |
| **Relevant Information** | |
| **Alcohol:** | **BMI:** |
|  |  |
| **BP:** | **Smoking Status:** |
|  |  |
| **Patient Sex:** |  |

|  |  |
| --- | --- |
| **For Reviewer use only** |  |
| **Reviewer** |  |
| **Date** |  |
| **Section 1.** Evidence provided meets the clinical criteria | ☐Yes ☐No |
| **Section 2.** Evidence provided of consent for referral | ☐Yes ☐No |
| **Section 3.** Appropriate sign-off | ☐Yes ☐No |
| **Full compliance** | ☐Yes ☐No |