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

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

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

History and Impairment: (eg, night pain, incidence of falls, safety issues, walking tolerance, ADLs,

work issues, imp	oact on co morbidi	ties, carer issues e	etc)		,
		related directly to the	nt history, date of on: he area of concern. s timely triage decis	set and impairments ions.	
Eversineties Ei	ndings: (og POM	WP status strengt	h gait nattern neur	ological changes, sp	ecial tests etc)
Examination Fi			n, gan panern, neur hance triage decisio		
	ITII	s iniormation will en	riance thage decisio	113.	
3. Provisional /	Working Diagnos	sis:			
	Please pro	vide the current wor	king diagnosis for yo	our patient.	
Parameter and the second secon				t de la	- h 11 t 1
4. Primary Purp	ose of Referral: F	Please complete as	Commonwed .	intment slot can ther	
Managem	ent/Treatment	Diagnosis	Review	ı 2 nd opinid	on
Other (sp.	ecify)				
Cirici (Sp					
An appointment ca	patient appointment annot be made for you atient can then be tradition results, and will knee	our patient without to	This will reduce the	stigations and reports a need for call back and times. Elbow to Wrist	other
XR – Charnley view AP Pelvis XR – Lateral Hip	XR – PA weightbearing XR – Lateral XR – Notch (intercondylar) View XR – Skyline view	If foot – weightbearing AP, Oblique and Lateral views If ankle – Weightbearing AP, Mortise and Lateral views	XR – AP and Lateral and Ultrasound Shoulder Special views as required	XR – AP and Lateral of region Special views (eg Scaphoid) as required	XR – AP and Lateral of region
interventions ML	Treatment to Date JST be included f	e: Please tick the for referral to be	appropriate box accepted so that	/boxes. Details o	f these e directed
appropriately.	Injections	Dhyoiotheyen	Hydrotherapy	Orthotics .	Other
Medications	Injections	<u>Physiotherapy</u>	nydrotherapy	<u> </u>	
Details/Results: P/	ease comment on th	he effectiveness of t	he treatment to date	9.	-

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

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Primary Purpose of Referral: Management/Treatment Diagnosis Review 2 nd opinion Other (specify) OArea of Concern: Please tick area to be assessed. The minimum investigations and ferral to be accepted, are outlined below. Hard copies MUST accompany the patient to the special view weightbearing AP, Oblique and Lateral views MR - Lateral Hip XR - Lateral Hip XR - Notch (intercondylar) If foot - weightbearing AP, Oblique and Lateral views If ankle - XR - AP and Lateral views Special views as (eg Scaphoi	rance, ADLs, work	valking tolerance, /	alla anfaturiaguas		UIPAHENI BOUKIN	RTHOPAEDIC O
Provisional / Working Diagnosis: Primary Purpose of Referral: Management/Treatment Diagnosis Review 2 nd opinion Other (specify) Other (specify) Charles of Concern: Please tick area to be assessed. The minimum investigations and afterral to be accepted, are outlined below. Hard copies MUST accompany the patient to the strength of the strength			alis, sajety issues,	ht pain, incidence of		
Other (specify) OArea of Concern: Please tick area to be assessed. The minimum investigations and referral to be accepted, are outlined below. Hard copies MUST accompany the patient to the hip Knee Foot & Ankle Shoulder XR - Charnley view AP Pelvis XR - Lateral Hip XR - Lateral XR - Notch (intercondylar) If foot - Weightbearing AP, Oblique and Lateral Views If ankle - Special views as (eg Scaphoi					co morbialties etc)	ssues, impact on
	ges, special tests etc	logical changes, spe	gait pattern, neuro	WB status, strength	ndings: (e.g, ROM,	. Examination Fi
Management/Treatment Diagnosis Review 2 nd opinion Other (specify) OArea of Concern: Please tick area to be assessed. The minimum investigations and referral to be accepted, are outlined below. Hard copies MUST accompany the patient to the hip Knee Foot & Ankle Shoulder XR - Charnley view AP Pelvis XR - Lateral XR - Notch (intercondylar) If foot - weightbearing AP, Oblique and Lateral views XR - AP and Lateral views If ankle - Shoulder Special views as Special views as		gladas V			orking Diagnosis:	. Provisional / W
Knee Foot & Ankle Shoulder	reports required, for	ations and reports	minimum investi	to be assessed. Th	nt/Treatment ify) n: Please tick area	Managemen Other (spec
AP Pelvis weightbearing weightbearing AP, AR – Lateral Hip XR – Lateral XR – Notch (intercondylar) Weightbearing AP, Oblique and Lateral Views Special views Special views as (eg Scaphoi		Elbow to Wrist				
View XR – Skyline view Weightbearing AP, Mortise and Lateral views required required	on of region	XR – AP and Lateral of region Special views (eg Scaphoid) as required	<u>and</u> Ultrasound Shoulder	weightbearing AP, Oblique and Lateral views If ankle — Weightbearing AP, Mortise and Lateral	weightbearing XR – Lateral XR – Notch (intercondylar) View	AP Pelvis

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Details/Results:

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