Austin Health **ORTHOPAEDIC OUTPATIENT BOOKING INFORMATION FORM**

GUIDELINES FOR USE

This form must be completed and 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, impact on co morbidities, carer issues etc)*

Please provide details of relevant current history, date of onset and impairments related directly to the area of concern. This information supports timely triage decisions.

Examination Findings: *(eg, ROM, WB status, strength, gait pattern, neurological changes, special tests etc)*

This information will enhance triage decisions.

3. Provisional / Working Diagnosis:

Please provide the current working diagnosis for your patient.

4. Primary Purpose of Referral: *Please complete as an appropriate appointment slot can then be allocated.*

☐ Management/Treatment ☐ Diagnosis ☐ Review ☐ 2nd opinion

☐ Other *(specify)*.....

5. Area of Concern: **Please tick area to be assessed. The minimum investigations and reports required, for the referral to be accepted, are outlined below. Hard copies MUST accompany the patient to the outpatient appointment.**

An appointment cannot be made for your patient without these minimum investigations and reports, accompanying the referral. Your patient can then be triaged appropriately. This will reduce the need for call back appointments to review the investigation results, and will significantly reduce overall clinic waiting times.

Hip	Knee	Foot & Ankle	Shoulder	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

6. Conservative Treatment to Date: **Please tick the appropriate box/boxes. Details of these interventions MUST be included for referral to be accepted so that the patient can be directed appropriately.**

Medications	Injections	Physiotherapy	Hydrotherapy	Orthotics	Other

Details/Results: *Please comment on the effectiveness of the treatment to date.*

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

Office Use ☐☐

Austin Health

ORTHOPAEDIC OUTPATIENT BOOKING INFORMATION FORM

PATIENT INFORMATION:

NAME: .....

DoB: .....

Austin UR No.: .....

1. History and Impairment: *(e.g, night pain, incidence of falls, safety issues, walking tolerance, ADLs, work issues, impact on co morbidities etc)*

2. Examination Findings: *(e.g, ROM, WB status, strength, gait pattern, neurological changes, special tests etc)*

3. Provisional / Working Diagnosis:

4. Primary Purpose of Referral:

☐ Management/Treatment ☐ Diagnosis ☐ Review ☐ 2nd opinion

☐ Other *(specify)* .....

5. 0Area of Concern: **Please tick area to be assessed. The minimum investigations and reports required, for the referral to be accepted, are outlined below. Hard copies MUST accompany the patient to the outpatient appointment.**

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