Hip & knee Replacement Referral Form

NHS Wirral

Please complete this referral form and fax either:

WUTH 0151 604 7172

Spire Murrayfield 0151 929 5311

Presenting Complaint:

Current & Relevant past Conditions:

Please tick relevant box:

Left ☐ Right ☐ Hip ☐ Knee ☐

Criteria	Level	
Movement and Deformity		
Restricted range of motion		
	• None • Mild • Moderate • Severe	☐ ☐ ☐ ☐
X-ray findings	• Date x-rayed…….. • None • Mild • Moderate • Severe • Bi-lateral • Unilateral	 ☐ ☐ ☐ ☐ ☐ ☐
MRI (If done which site)	• CBH • CCO • Other …….	☐ ☐
Other Factors		
Multiple joint involvement	• No single joint • Yes, each affected joint mild (moderate in severity • Yes, severe involvement (e.g. severe rheumatoid arthritis)	☐ ☐ ☐
Ability to work, care for dependant/s or live independently (difficulty must be related to affected joint)	• Not threatened or difficult • Not threatened but more difficult • Threatened, but not immediately • Immediately threatened	☐ ☐ ☐ ☐
Has the patient undergone any physiotherapy for the condition?	• Yes • No	☐ ☐
Medications Anticoagulants Clopidogrel **Other Medications**	• Yes • No • Yes • No	☐ ☐ ☐ ☐

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Is the patient currently prescribed regular / maximum tolerated analgesia or has received an intra-articular injection?	• Yes • No	☐ ☐
What is the BMI of the patient?	<30 ☐ 30-35 ☐ 35-40 ☐ 40+ ☐	
If the BMI>30 has the patient been referred to WLMS or are they involved in other active weight loss intervention?	• Yes • No	☐ ☐
Blood Pressure Dipstick Urine Glycosuria Proteinuria (one + or more)	..... …… Yes ☐ No ☐ Yes ☐ No ☐	

Title: Mr ☐ Mrs ☐ Miss ☐ Ms☐ **Other:** …….. **Surname:** **Forenames:**	**NHS number:** **DOB:** **Age:**
<u>Permanent Address</u> **Post code**: **Telephone:**	**<u>Current Address</u>** (if different) **Post code:** **Telephone:**
<u>GP details</u> **Name:** **Surgery:**	**<u>Ethnic Origin</u>**

<u>Patient information given</u>
Yes ☐ No ☐

A GuideTo Total Hip Replacement00188.p

A GuideTo Total Knee Replacement00

18 week wait has been discussed with the patient: Yes ☐ No ☐	**Can you confirm all conservative management options have been exhausted and the patient requires surgery: Yes ☐ No ☐**

Referrer Details:
Name:

Signature: …… **Designation:** ……

Date: …….. **Contact number:** ……..

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