**Referral Form for Consideration of CARPAL TUNNEL SURGERY**

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| **PATIENT DETAILS** |
| Date of Referral: |  | Date Referral Received: |  |
| GP Practice: |  | Referring GP: |  |
| Patient Name: |  | Patient Date of Birth: |  |
| Patient Address: |  | Patient Contact Number: |  |
| NHS Number: |  | Hospital Number (if known): |  |
| **POLICY CRITERIA – the full policy is accessible via this link**[**http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/?assetdet1029359=39309**](http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/?assetdet1029359=39309) |
| Please provide the approved indication for referral and complete the signs and symptoms table overleaf:1. **RED FLAG**

*Fracture, Onset of tingling/numbness after injury, Nerve/other suspected tumour*1. **YELLOW FLAG**

*Neurological disease, Active inflammatory joint disease, Peripheral limb ischaemia, Cervical nerve root entrapment*1. Symptoms consistent with **SEVERE** disease (immediate referral)
2. Symptoms consistent with **MILD or MODERATE** disease PROVIDING that the patient has:
3. Failed wrist splints (12 weeks assured use at night)

AND1. Temporary improvement (< 6 weeks) following corticosteroid injection OR

Positive Nerve Conduction Study (moderate or severe) AND1. Assured value and need for surgery on the basis of symptoms

 AND1. Patient willing to proceed to surgery
 | **Tick Applicable Indication****Emergency referral to A&E****Urgent speciality referral within 2 weeks**□□Please circle as appropriate:Yes\*Yes\*\* / NoORModerate\*\* / Severe\*\*Yes\*Yes\*\* *required**\*\* one of these required* |
| **EXAMINATION/PMH/DH/ALLERGIES** |
| *See table overleaf for signs and symptoms* |
| **SIGNS AND SYMPTOMS** |
| **Known duration: .………mths …….…yrs** | **MILD to MODERATE** | **SEVERE**(all required for immediate referral) |
| **Paraesthesia in correct distribution** (thumb, index, middle) | □ Intermittent | □ Persistent |
| **Numbness and weakness** (in correct distribution) | □ None | □ Persistent |
| **Symptom occurrence** | □ Exacerbation at night□ Regular night waking | □ Daily with frequent night waking |
| **Thumb weakness/loss of co-ordination**(thenar muscle)  | □ Subjective□ Objective | □ Objective |
| **Thenar muscle wasting** |  | □ Visible |
| **OTHER CLINICAL CONSIDERATIONS** |
| Are there any co-morbidities that need to be considered before surgery?(please provide details above) | Yes [ ]  No [ ]  |
| Have relevant co-morbidities been optimised as far as possible and the patient is willing to consider surgery at the time of referral? | Yes [ ]  No [ ]  |
| **PATIENTS NOT MEETING THE POLICY** |
| For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has clinically exceptional circumstances, an Individual Funding Request may be considered. The referring clinician should consult the Commissioner’s “Operational Policy for Individual Funding Requests” document for further guidance on this process. <http://www.redditchandbromsgroveccg.nhs.uk/strategies-policies-and-procedures/commissioning-ifr-policies-a-z/> |