

Patient Information
Title and Surname: \${Title_and_surname} Forename: \${Forename}
Address: \${Patient_address}
Date of Birth: \${Date_of_birth} NHS Number: \${NHS_number}
Consultant/Service to whom referral will be made:
Hospital:

Please send this form with the referral letter or to the consultant who you sent the referral to

Lifestyle Information		
Latest BMI: \${Latest_BMI}	Latest BP: \${Latest_BP}	Smoking Status:
Has the patient been referred for:		
<input type="checkbox"/> Weight Management	<input type="checkbox"/> Smoking Cessation	

Information Governance Statement

All Prior Approval Requests must be reviewed by the clinical commissioning group (CCG) as the statutory body responsible for funding decisions. This application form and other supporting information supplied may be shared with the CCG. If so, personal information will be retained only for the purposes of this Prior Approval Request and, in some cases, may be used for invoicing and payment reconciliation. The patient's medical records may be used for the purpose of clinical audit which will be completed by a clinician. Anonymised information may also be shared as part of the CCG reporting process.

Does the patient consent to the sharing of their personal information? Y/N

Refusal of consent will not preclude application of this referral. However, the referring body must ensure that all personal identifiable data is redacted from this application.

T18b – Knee Replacement

Instructions for use:

To GPs: Please refer to the full policy and complete the box below prior to referral and provide evidence to support the criteria.

To Consultants: Please refer to the full policy, complete the box below and ensure there is evidence that the criteria are met.

Patients should only be referred for consideration of knee replacement surgery for osteoarthritis if they experience joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life, as demonstrated by:

EITHER: Intense to severe persistent pain (defined in Table 1) leading to severe functional limitation (defined in Table 2) for a period of at least 3 months	<input type="checkbox"/>
OR Moderate to severe functional limitation (defined in Table 2) affecting quality of life (in the opinion of the clinician(s) on the local CCG Knee Pathway) for a period of at least 3 months	<input type="checkbox"/>
AFTER having completed "Stage 2 – Preparation for Surgery" of the local CCG Knee Pathway Date Completed:	<input type="checkbox"/>
AND the following core treatments for at least 3 months: 1. Patient education: such as elimination of damaging influence on knees, activity modification	<input type="checkbox"/>

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MOM v8.4

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(avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment 2. Activity and Exercise: e.g. physiotherapy	
AND Weight loss: IF the patient has a BMI>35kg/m ² then they should have evidence of participating in a weight management programme in order to reduce the risks associated with joint replacement surgery. This should be for a period of at least 6 months prior to referral for surgery. BMI	<input type="checkbox"/>
AND trialled appropriate Pain relief: Paracetamol-based analgesics, oral NSAIDs or COX-2 inhibitors for a minimum of 3 weeks . Opioid analgesics can be used effectively if paracetamol or NSAIDs are ineffective or poorly tolerated.	<input type="checkbox"/>
AND received at least one additional non-operative therapy: e.g. manual therapy (e.g. physiotherapy), supports and braces, shock absorbing shoes or insoles, local heat and cold therapy. Intra-articular corticosteroid injections may also be provided (when facility is available in primary/intermediate care).	<input type="checkbox"/>
AND if the patient currently smokes then they should routinely be offered advice and support to help stop smoking, and patients should participate in a smoking cessation programme for a period of at least 3 months prior to referral for surgery.	<input type="checkbox"/>

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request (IFR) policy for further details.

Please Indicate: LEFT KNEE RIGHT KNEE

NB If more than one joint replacement is being considered **EACH** surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

Clinical exceptions to the criteria in this policy are:

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement surgery would relieve this	<input type="checkbox"/>
Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure	<input type="checkbox"/>

Table 1: Classification of pain level

Pain Level	
Slight Pain	Sporadic pain.(May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate Pain	Occasional pain.)May be daily and occurs 50-75% of one's day Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense Pain	Pain of almost continuous nature.(Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems walking stick, crutches).

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Severe Pain	<p>Continuous pain. (Occurs 100% of the time)</p> <p>Pain when resting or pain at night.</p> <p>Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress)</p> <p>Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.</p> <p>Requires more constant use of support systems (walking stick, crutches).</p>
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Table two: Functional Limitations

Minor	<p>Functional capacity adequate to conduct normal activities and self-care</p> <p>Walking capacity of more than one hour</p> <p>No aids needed</p>
Moderate	<p>Functional capacity adequate to perform only a few of the normal activities and self-care</p> <p>Walking capacity of between half and one hour</p> <p>Aids such as a cane are needed occasionally</p>
Severe	<p>Largely or wholly incapacitated</p> <p>Walking capacity of less than half hour</p> <p>Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.</p>

Consultant Use Only
Please complete the following and file for future compliance audit.
Referral criteria is met and Clinical details documented in patient notes?
Yes <input type="checkbox"/> / No <input type="checkbox"/>
Signature:
Date:
Consultant:
Provider:

GP Use Only
Practice Stamp/Address: \${Registered_GP_address}
Referring clinician: \${Referring_doctor}
Referral Date: :\${Todays_date}

Commissioner's Use Only
Criteria met as per Policy?
Yes <input type="checkbox"/> / No <input type="checkbox"/>
Compliance with notes?
Yes <input type="checkbox"/> / No <input type="checkbox"/>
Audit Date:
Audited By:

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