Monash Health Referral Guidelines
ORTHOPAEDICS

EXCLUSIONS

Services not offered by Monash Health

Acute fractures must present to Emergency Department
Patients under 18 years of age: Click here for Monash Children's Orthopaedic guidelines

CONDITIONS

NECK
- Mechanical neck pain w/o arm pain
- Neck pain associated with referred arm pain
- Neck pain associated with radicular symptoms
- Cervical myelopathy
- Neck pain secondary to malignant disease
- Neck pain secondary to infection

SHOULDERS
- Rotator cuff tendonitis/tears
- Pain/stiffness in shoulders
- Osteoarthritis
- AC joint problems
- Recurrent dislocated shoulder/shoulder instability

ELBOWS
- Tendonitis
- Painful/stiffness in elbow

HANDS AND WRISTS
- Contractures and Dupuytrens
- Stenosing tenovaginitis eg. trigger finger
- Arthritis
- Ganglia
- Painful/stiff wrists

BACK
- Mechanical low back pain without leg pain
- Mechanical low back pain with leg pain
- Spinal stenosis with limitation of walking distance
- Back pain secondary to neoplastic disease

HIPS
- Osteoarthritis
- Inflammatory arthritis
- Post traumatic arthritis
- Avascular necrosis

KNEES
- Osteoarthritis
- Inflammatory arthritis
- Post traumatic arthritis
- Avascular neurosis

ANKLES AND FEET
- Arthritis
- Pain & deformity in forefoot (incl bunions)
- Pain & instability in hind foot
- Achilles tendon pathology
- Heel pain
- Plantar Fasciitis

MISCELLANEOUS
- Nerve entrapment
- Bone or joint infection
- Bone and soft tissue tumours
- Bursitis

Head of unit: Mr Ton Tan

Program Director: Mr Alan Saunder

Last updated: 07/05/2024

Monash Health Referral Guidelines
ORTHOPAEDICS

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY	For emergency cases please do any of the following: - send the patient to the Emergency department OR - Contact the on call registrar OR - Phone 000 to arrange immediate transfer to ED
URGENT	The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.
ROUTINE	The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

Secure eReferral by HealthLink is now our preferred method of referral.

https://auportal.healthlink.net/hlkportal/login

How to refer to Monash Health

Find up-to-date information about how to send a referral to Monash Health Specialist Consulting Clinics on the eReferrals page on our website.

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact on call registrar via Monash Health switchboard on 9594 6666

General enquiries

Phone: 1300 342 273

Head of unit:	Program Director:	Last updated:
Mr Ton Tan	Mr Alan Saunder	07/05/2024

MonashHealth

NECK

MECHANICAL NECK PAIN WITHOUT ARM PAIN

Initial GP Work Up

- Duration of symptoms
- Work status
- Treatment to date
- General medical condition

Investigations:

- X-ray
- CT Scan with oblique sagittal reconstruction
- FBC & ESR & CRP
- Biochemistry
- (Consider calcium and phosphate, protein electrophoresis, immunoglobulins, PSA, Rheumatoid serology in specific cases.)

Management Options for GP

- Trial of soft collar
- Physiotherapy
- Activity modification
- Analgesics and non-steroidal anti-inflammatories
- Refer to pain clinic, Rheumatology or Neurosurgery as appropriate

WHEN TO REFER?

Routine

No surgical intervention is indicated for any mechanical neck pain without neurological symptoms.

BACK

NECK PAIN ASSOCIATED WITH REFERRED PAIN TO THE UPPER ARM WITHOUT NEUROLOGICAL DEFICIT

Initial GP Work Up

- Presence of neurological symptoms and signs including evidence of upper limb spasticity
- Weight loss, appetite loss and lethargy
- Fever and sweats
- Previous malignant disease

Investigations:

- X-ray
- CT Scan with oblique sagittal reconstruction
- FBC & ESR & CRP
- Biochemistry

*Consider calcium and phosphate, protein electrophoresis, immunoglobulins, PSA, Rheumatoid serology in specific cases.)

Management Options for GP

- Trial of soft collar
- Physiotherapy
- Activity modification
- Analgesics and non-steroidal anti-inflammatories
- Refer to pain clinic, Rheumatology or Neurosurgery as appropriate

WHEN TO REFER?

Routine

No surgical intervention is indicated for any mechanical neck pain without neurological symptoms.

BACK

NECK (cont'd)

NECK PAIN ASSOCIATED WITH RADICULAR SYMPTOMS AND NEUROLOGICAL DEFICIT, CERVICAL MYELOPATHY, NECK PAIN SECONDARY TO MALIGNANT DISEASE, NECK PAIN SECONDARY TO INFECTION

Initial GP Work Up

- Presence of neurological symptoms and signs including evidence of upper limb spasticity
- Weight loss, appetite loss and lethargy
- Fever and sweats
- Previous malignant disease

Investigations:

- X-ray
- CT Scan with oblique sagittal reconstruction
- FBC & ESR
- Biochemistry

* Consider calcium and phosphate, protein electrophoresis, immunoglobulins, PSA, Rheumatoid serology in specific cases

Management Options for GP

- Highlight applicable symptoms in referral and refer early. **DO NOT** observe these symptoms.
- Consider referral to Neurosurgery as appropriate

WHEN TO REFER?

Urgent

If further symptoms present:

- weight loss/loss of appetite,
- lethargy,
- fevers and sweats,
- previous malignant diseases,
- urinary difficulties,

Or if failure to respond to conservative treatment after six months

BACK

SHOULDERS

ROTATOR CUFF TENDONITIS/TEARS

Initial GP Work Up

- Standard history and examination particularly neurological examination
- X-rays (standard views)
- Consider FBC & ESR
- Ultrasound examination

Management Options for GP

- Anti inflammatories
- Physiotherapy
- Consider Ultrasound guided Cortisone injections
- Regular stretching exercises

WHEN TO REFER?

Urgent

- Associated constitutional symptoms with severe pain and acute loss of range of movement
- Large cuff tear following dislocation

Routine

- If condition fails to respond after six months of conservative treatment unless evidence of weakness suggestive of an acute rotator cuff tear which should be referred as semi-urgent

NOTE: An appointment will be with a senior clinician physiotherapist at the Physiotherapist Led orthopaedic shoulder clinic and not with an Orthopaedic surgeon. For initial assessment & prioritisation.

BACK

PAIN/STIFFNESS IN SHOULDER (FROZEN SHOULDER)

Initial GP Work Up

- Standard history and examination particularly neurological examination
- X-rays (standard views) & Ultrasound
- Consider FBC & ESR

NB – Limited external rotation indicative of Frozen Shoulder

Management Options for GP

- Anti inflammatories
- Physiotherapy
- Consider a hydrodilatation injection
- Regular stretching exercises
- Self directed pod exercises

WHEN TO REFER?

Urgent

Associated fevers & constitutional symptoms

Routine

- If condition fails to respond after six months of conservative treatment

NOTE: An appointment will be with a senior clinician physiotherapist at the Physiotherapist Led orthopaedic shoulder clinic and not with an Orthopaedic surgeon. For initial assessment & prioritisation.

BACK

SHOULDERS (cont'd)

OSTEOARTHRITIS

Initial GP Work Up

- Standard history and examination particularly neurological examination
- X-rays (standard views) & Ultrasound
- Consider FBC & ESR

Management Options for GP

- Anti inflammatories
- Physiotherapy
- Consider Ultrasound guided Cortisone injections
- Regular self-directed exercises/programs

WHEN TO REFER?

Urgent

Fevers / constitutional symptoms

Routine

- If condition fails to respond after six months of conservative treatment unless evidence of weakness suggestive of an acute rotator cuff tear which should be referred as semi-urgent

NOTE: An appointment will be with a senior clinician physiotherapist at the Physiotherapist Led orthopaedic shoulder clinic and not with an Orthopaedic surgeon. For initial assessment & prioritisation.

BACK

AC JOINT PROBLEMS

Initial GP Work Up

- Standard history and examination particularly neurological examination
- X-rays (standard views)
- Consider FBC & ESR

Management Options for GP

- Anti inflammatories
- Physiotherapy
- Consider Ultrasound guided Cortisone injections
- Regular stretching exercises
- Work considerations

WHEN TO REFER?

Urgent

All traumatic AC joint dislocations

Routine

- If condition fails to respond after six months of conservative treatment unless evidence of weakness suggestive of an acute rotator cuff tear which should be referred as semi-urgent

NOTE: An appointment will be with a senior clinician physiotherapist at the Physiotherapist Led orthopaedic shoulder clinic and not with an Orthopaedic surgeon. For initial assessment & prioritisation.

BACK

SHOULDERS (cont'd)

RECURRENT DISLOCATED SHOULDER/SHOULDER INSTABILITY

Initial GP Work Up

- Standard history and examination particularly neurological examination.
- In older patients' difficulty elevating the arm following a dislocation. Consider ultrasound examination of rotator cuff.
- X-rays (standard views) & Ultrasound
- Consider FBC & ESR.

Management Options for GP

- Shoulder rehabilitation programme (Physiotherapy)

WHEN TO REFER?

Urgent

Irreducibility

Routine

- If condition fails to respond after six months of conservative treatment unless evidence of weakness suggestive of an acute rotator cuff tear which should be referred as semi-urgent

NOTE: An appointment will be with a senior clinician physiotherapist at the Physiotherapist Led orthopaedic shoulder clinic and not with an Orthopaedic surgeon. For initial assessment & prioritisation.

BACK

ELBOWS

TENDONITIS

WHEN TO REFER?

Initial GP Work Up

Standard history and examination

- X-ray

Management Options for GP

- Do not consider cortisone injection
- Physiotherapy
- Supports – Tennis Elbow strap
- Analgesics/anti inflammatories
- Activity Modification
- Work Assessment

Routine

Elbow Tendonitis does not require surgical intervention

BACK

PAINFUL/STIFFNESS IN ELBOW

WHEN TO REFER?

Initial GP Work Up

- Standard history and examination
- Consider FBC & ESR
- X-Ray

Management Options for GP

- Anti-inflammatories
- Physiotherapy
- Work Assessment

Routine

If not responding to treatment after six months

BACK

HANDS AND WRISTS

CONTRACTURES & DUPUYTRENS

WHEN TO REFER?

Routine

If progressive contractures (especially PIP contractures) with functional impairment as routine

Initial GP Work Up

- Duration and speed of progression
- Functional impairment
- Family history of Dupuytrens
- Previous surgery
- General medical conditions (especially diabetes, epilepsy, liver disease)
- Medications (especially for epilepsy)

Management Options for GP

- Stretching
- Physiotherapy / hand therapy
- Braces
- Diabetes Control
- Cease Smoking

BACK

STENOSING TENOVAGINITIS (e.g. TRIGGER FINDERS, DE QUERVAINS

WHEN TO REFER?

Routine

If functional impairment or if unresponsive to treatment

Initial GP Work Up

- Standard history and examination
- X-ray

Management Options for GP

- Consider steroid injection under image control

BACK

HANDS AND WRISTS (cont'd)

ARTHRITIS

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination
- X-Ray

Management Options for GP
- Anti-inflammatories
- Occupational Therapy
- Work Assessment
- Activity modification
- Consider steroid injection

Routine

After six months if condition fails to respond to conservative management

BACK

GANGLIA

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination
- X-ray

Management Options for GP
- Insert relevant information

Routine

Routine for symptomatic ganglia.

NB: Cosmetic reason alone usually is not a reason for referral

BACK

PAINFUL/STIFF WRISTS

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination
- X-Rays to include scaphoid views

Management Options for GP
- Anti-inflammatories
- Trial of wrist splint
- Physiotherapy
- Consider steroid injection

Routine

If condition fails to respond after six months of conservative treatment

BACK

BACK

MECHANICAL LOW BACK PAIN WITHOUT LEG PAIN

WHEN TO REFER?

Initial GP Work Up

- Standard history and examination
- X-Rays (allow exclusion of some diagnosis)
- Previous spinal surgery

Routine

No surgical intervention is indicated for any mechanical back pain without neurological symptoms

Management Options for GP

- Active Physiotherapy treatment
- Aquatic physiotherapy
- Analgesia
- Activity modification
- Refer to pain management clinic or Rheumatology
- Weight Loss
- Cease Smoking

BACK

MECHANICAL LOW BACK PAIN WITH LEG PAIN, SPINAL STENOSIS BACK PAIN WITH LIMITATION OF WALKING DISTANCE, BACK PAIN SECONDARY TO NEOPLASTIC DISEASE OR INFECTION

WHEN TO REFER?

Initial GP Work Up

- Neurological deficit
- Duration of symptoms
- Functional impairment
- Time off work
- Treatment to date
- Previous spinal surgery
- General medical condition and medication

Investigations:

- X-Rays, FBC ESR Biochemistry
- Spinal Stenosis – CT

Management Options for GP

- Activity modification
- Analgesics and NSAIDs
- Physiotherapy
- Refer to pain management clinic or Rheumatology

* Consider calcium and phosphate, electrophoresis, immunoglobulins, PSA, arthritis serology in specific cases including ankylosing spondylitis

Emergency

If bilateral sciatica with perineal sensory disturbance, sphincteric disturbance with or without progressive neurological symptoms – straight to Emergency Department

NB Casey not suitable for this admission

Urgent

If further symptoms present:

- weight loss/loss of appetite,
- lethargy,
- fevers and sweats,
- previous malignant diseases,
- urinary difficulties,
- walking distance < 50 metres).

Or if failure to respond to conservative treatment after six months

BACK

HIPS

OSTEOARTHRITIS, INFLAMMATORY ARTHRITIS, POST TRAUMATIC ARTHRITIS, AVASCULAR NECROSIS

Initial GP Work Up

- Standard history and examination
- Walking distance
- Rest pain and disturbance of sleep
- Locking and/or instability
- Ability to put on shoes
- Use of walking aids
- Treatment including NSAIDs and analgesics
- Previous joint surgery
- General medical conditions and medication
- History of recurrent infections and prostatism

Investigations:

- X-ray (AP pelvis, AP affected hip showing proximal 2/3 femur, and lateral affected hip)

Management Options for GP

- Anti-inflammatories/ analgesics (with guidance around taking analgesics prior to exercise/walking)
- Physiotherapy
- Gradual walking program
- Activity modification including the use of gait aids
- Conservative management (consider MBS Allied Health items for referral to allied services)
- Dietetics if BMI > 32
- Work Assessment
- Diabetes Control
- Cease Smoking

NOTE: An appointment will be made with the musculoskeletal coordinator at Osteoarthritis Hip & Knee Service and not with an Orthopaedic surgeon.
The Osteoarthritis Hip and Knee Service is a state-wide initiative aimed at reducing Orthopaedic appointment and orthopaedic surgery waiting lists. For more information on this initiative click on the link below:
www.health.vic.gov.au/oahks/informaton.htm

WHEN TO REFER?

Emergency

- Acute exacerbated pain with inability to weight bear
- Associated constitutional symptoms

Urgent

- Progressive symptoms
- Progressive loss of mobility

Routine

If significant pain, problems relating to mobility, sleep disturbance and unresponsive to the above conservative therapies.

BACK

KNEES

OSTEOARTHRITIS, INFLAMMATORY ARTHRITIS, POST TRAUMATIC ARTHRITIS, AVASCULAR NECROSIS

Initial GP Work Up

- Standard history and examination
- Walking distance
- Rest pain and disturbance of sleep
- Beware of pain in the knee as a symptom of hip disease
- Use of walking aids.
- Treatment including NSAIDs and analgesics.
- Previous joint surgery.
- General medical condition and medication.
- History of recurring infections and prostatism.

Investigations:

- X-rays of four standard views **plus standing AP**
- Ultrasound/CT/MRI **NEVER** required

Management Options for GP

- Anti-inflammatories/ analgesics (with guidance around taking analgesics prior to exercise/walking)
- Physiotherapy
- Gradual walking program
- Activity modification including the use of gait aids.
- Conservative management (consider MBS Allied Health items for referral to allied services)
- Dietetics if BMI > 32
- Work Assessment
- Diabetes Control
- Cease Smoking

NOTE: An appointment will be made with the musculoskeletal coordinator at Osteoarthritis Hip & Knee Service and not with an Orthopaedic surgeon.

The Osteoarthritis Hip and Knee Service is a state-wide initiative aimed at reducing Orthopaedic appointment and orthopaedic surgery waiting lists. For more information on this initiative click on the link below:
www.health.vic.gov.au/oahks/informaton.htm

WHEN TO REFER?

Emergency

- Acute exacerbated pain with inability to weight bear
- Associated constitutional symptoms

Urgent

- Progressive symptoms
- Progressive loss of mobility

Routine

If significant pain, problems relating to mobility, sleep disturbance and unresponsive to the above conservative therapies.

BACK

ANKLES & FEET

ARTHRITIS

Initial GP Work Up
- Standard history and examination
- X-Rays

Management Options for GP
- Analgesics/anti inflammatories
- Physiotherapy
- Activity modification
- Walking aids
- Weight loss
- Exercise
- Consider steroid injection

WHEN TO REFER?

Emergency
- Acute exacerbated pain with inability to weight bear
- Associated constitutional symptoms

Urgent
- Progressive symptoms
- Progressive loss of mobility

Routine
If condition fails to respond to conservative treatment after six months

BACK

PAIN AND DEFORMITY IN FOREFOOT (INCLUDING BUNIONS)

Initial GP Work Up
- Standard history and examination
- Weight-bearing AP/lateral foot x-ray

Management Options for GP
- Modification footwear
- Orthoses
- Weight Loss
- Diabetes Control
- Cease Smoking
- Consider steroid injections for intermetatarsal bursa/neuroma

WHEN TO REFER?

Emergency
Infection in diabetic foot

Urgent
At risk foot with unhealing ulcer

Routine
If condition fails to respond to conservative treatment after six months

BACK

ANKLES & FEET (cont'd)

PAIN AND INSTABILITY IN HIND FOOT

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination
- Ankle X-Rays

Management Options for GP
- Modification footwear
- Orthoses
- Physiotherapy
- Consider steroid injection
- Weight Loss
- Diabetes Control
- Cease Smoking

Emergency
Post trauma refer to ED

Urgent
Severe progressive loss of mobility

Routine
If condition fails to respond to conservative treatment after six months

BACK

ACHILLES TENDON PATHOLOGY

WHEN TO REFER?

Initial GP Work Up
- Standard history and examination
- Ankle X-Rays
- Ultrasound of Achilles Tendon

Management Options for GP
- Physiotherapy
- Consider steroid injections to bursa
- Activity Modification
- Orthoses – heel cups / raise
- Diabetes Control
- Exercise
- Weight Loss
- Cease smoking

Routine
If condition fails to respond to conservative treatment after six months

BACK

ANKLES & FEET (cont'd)

HEEL PAIN

Initial GP Work Up

- Standard history and examination
- X-Rays (allow exclusion of some diagnosis)

NB: Calcaneal Spur is **NOT** a relevant X-ray finding

Management Options for GP

- Physiotherapy
- Activity Modification
- Orthoses – Heel cups / raise
- Weight Loss

WHEN TO REFER?

Routine

Abnormal X-rays

BACK

PLANTAR FASCIITIS

Initial GP Work Up

- Standard history and examination
- X-Rays (allow exclusion of some diagnosis)

NB: Plantar Spurs on an X-ray does not infer plantar fasciitis

Management Options for GP

- Physiotherapy
- Consider Steroid Injection
- Orthoses

WHEN TO REFER?

Routine

Plantar Fasciitis does not require surgical intervention

BACK

MISCELLANEOUS

NERVE ENTRAPMENT SYNDROME

Initial GP Work Up

- Standard history and examination

Management Options for GP

- Consider one steroid injection for carpal tunnel
- Splinting

WHEN TO REFER?

Emergency

Acute or progressive neurological symptoms

Routine

- If muscle wasting is present.
- Prolonged or progressive symptoms.

BACK

BONE AND/OR JOINT INFECTION

Initial GP Work Up

- Standard history and examination
- X-Ray / CT
- Bloods
- Do not give antibiotics as will negate cultures

Management Options for GP

If ACUTE, please do not give antibiotics before referral

WHEN TO REFER?

Emergency

Refer to Emergency Department if acute

Routine

If chronic to Orthopaedic Clinic

BACK

MISCELLANEOUS (cont'd)

BONE AND SOFT TISSUE TUMOURS

Initial GP Work Up

- Standard history and examination including:
- X-Ray
- Ct of abnormal area
- Ultrasound
- FBE and U&E
- ESR/CRP/LFT

NEVER needle biopsy/inject/aspirate

Management Options for GP

N/A

WHEN TO REFER?

Emergency

Present to ED or via consultation with on-call team (Monash Health switchboard 9594 6666).

- Impending fracture
- Patients with metastatic conditions

Urgent

Refer all primary tumours directly to Peter MacCallum Cancer Centre. Please call for guidance

BACK

BURSITIS (PRE PATELLA, TROCHANTERIC, OLECRANON)

Initial GP Work Up

- X-ray
- Standard history and examination including:
- Acute/inflammatory, consider aspirating for diagnosis. Will either be traumatic, gouty or infected

Management Options for GP

- If acute, consider aspirating for relief of symptoms. Do not incise
- If chronic, consider steroid injection
- Avoid repeated injections
- Physiotherapy

WHEN TO REFER?

Emergency

If infective refer to Emergency Department

Urgent

If presents with severe pain / discharging

Routine

If condition fails to respond after six months of conservative treatment

BACK