# 07. CARPAL TUNNEL REFERRAL FORM

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| --- | --- | --- | --- |
| Date of Referral | Referral date | Referring GP | Sender title and full name |
| Patient Name | Forename Surname | Address | Sender address buildingSender address roadSender address post town |
| Address | Patient address housePatient address roadPatient address post town |
| Postcode | Patient post code | Postcode | Sender post code |
| Age/DOB | Patient AgeDate of birth | Fax No | Registered GP fax number |
| Tel No | Patient preferred telephone | Tel No | Registered GP phone number |
| NHS No | NHS number | Hospital No |       |

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| --- |
| Diagnosis and relevant history:      |
| Current (incl repeats) and past relevant medication & reason for stopping:      |
| Allergies:Allergies |

### Referral Criteria (tick those that apply):

*Funding will be considered the where patient meets criteria (see below). The clinician needs to ensure that the patient fulfils all the criteria before they are referred to secondary care. Where the patient does not fulfil the criteria the Exceptions Form will need to be completed. This can be found on the CCG’s website In order to do this the Exceptional Circumstances Submission form will need to be completed and can be found on the CCG’s website* [*http://www.valeofyorkccg.nhs.uk/rss/data/uploads/polvs/june-2015/voy-exceptions-submission-form.doc*](http://www.valeofyorkccg.nhs.uk/rss/data/uploads/polvs/june-2015/voy-exceptions-submission-form.doc)

NHS Vale of York CCG does not routinely commission surgical decompression for the treatment of carpal tunnel syndrome.

Nerve conduction studies are NOT generally needed to confirm the diagnosis. In elderly patients the condition may develop insidiously and nerve conduction studies may be useful to assess severity.

***Severe advanced***

* Advanced or severe neurological symptoms of CTS such as constant pins and needles, numbness, muscle wasting and prominent pain [ ]

**AND**

* Symptoms significantly affecting activities of daily living [ ]
* Symptoms have persisted despite a minimum of 6 months of conservative treatment with analgesia, local corticosteroid injection and / or nocturnal splinting for each requested side and lifestyle modification

***Moderate symptoms***

* A diagnosis of CTS is certain (where there is diagnostic uncertainty a specialist opinion is required) [ ]
* The patient has not responded to a minimum of 6 months of conservative management, including: [ ]
	+ >8 weeks of night-time use of wrist splints
	+ Appropriate analgesia
	+ Corticosteroid injections (given at least twice prior to referral) in appropriate patients
	+ Lifestyle modification, as appropriate, including weight loss if BMI over 30
* The symptoms are interfering with activities of daily living [ ]

**Treatment in all other circumstances is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request Panel.**

If the patient does not meet any of the above criteria state reason for referral:

Has funding been approved by the Individual Funding Request Panel

(Please tick) [ ]

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### For Trust usage

Patient listed for surgery: Yes [ ]  No [ ]

Comments: