Doncaster Community Carpal Tunnel Service Referral Form

Winterton Medical Practice

Manlake Avenue, Winterton DN15 9TA – 01724 734040

Patients Name:	D.O.B:
Address:	NHS No:
	Tel No:
Date of Referral:	
Referring GP, GP Address & Contact Details:	
History and details of referral/active problems:	

To be completed with the patient:

Carpal Tunnel Syndrome Diagnostic Questionnaire	**Yes**	**No**	**N/A**
Has pain in the wrist woken you at night?	1	0	
Has the tingling and numbness in your hand woken you during the night?	1	0	
Has the tingling and numbness in your hand been more pronounced first thing in the morning?	1	0	
Do you have/perform any trick movements to make the tingling numbness go from your hands?	1	0	
Do you have tingling and numbness in your little finger at any time?	-3	0	
Has tingling and numbness presented when you were reading a newspaper, steering a car or knitting?	1	0	
Do you have any neck pain?	-1	0	
Has the tingling and numbness in your hand been severe during pregnancy?	1	-1	0
Has wearing a splint on your wrist helped the tingling and numbness?	+2	0	0
TOTAL			

- A score of <3 is unlikely to be indicative of Carpal Tunnel Syndrome
- A score of 3-4 suggests Carpal Tunnel Syndrome is possible cause of symptoms
- A score of 5 or more is strongly suggestive of Carpal Tunnel Syndrome

If the score is 3 or more, please see second page for referral criteria.

The CCG will only fund Carpal Tunnel Surgery when the following criteria are met:

In ordinary circumstances*, referral should not be considered unless the patient **meets one or more** of the following criteria:	Delete as appropriate	
Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms that significantly interfere with daily activities)**	Yes	No
If there is no improvement in mild-moderate symptoms after 6 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of the dates and type(s) of conservative measures is required)	Yes	No

*If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information.
** This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.
Please see document below for full details:

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Patients History/Allergies/Medication (especially coagulants)
Allergies:
Medication:

Completed Referrals can be posted the above address or emailed to
NLCCG.WintertonChooseBook@nhs.net
Referrals also available through NHS Electronic Referrals System

To be completed by Surgeon:

Date Assessed:	Date Operated:
Clinical Notes:	