Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Arthroscopic Subacromial Decompression of the Shoulder (ASAD)

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund ASAD when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **ALL** of the following criteria.*	Delete as appropriate	
Patient has had symptoms for at least 3 months from the start of treatment **AND**	Yes	No
Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	Yes	No
Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND**	Yes	No
Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND**	Yes	No
Referral is at least 8 weeks following steroid injection **AND**	Yes	No
Patient confirms that they wish to discuss surgical treatment options	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG Individual Funding Request policy for further information.*

Primary Subacromial decompression in isolation is not normally funded unless the patient has a massive subacromial spur scoring the muscle and may otherwise require a cuff repair.