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

Please send this form with the referral letter.

Carpal Tunnel Syndrome Surgery.

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 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 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.

*** plus CTS score of 5 or more for Doncaster, Bassetlaw and Sheffield