# **Oxford Bone Infection Unit Referral**

**(Please do not use this form for 2 week target cancer referrals)**

Hospital referrals should be sent on this form directly to: [boneinfection.noc@nhs.net](mailto:boneinfection.noc@nhs.net)

GP referrals should be forwarded via the e-referral service to OUH.

Please ensure that all relevant imaging has been transferred to us electronically via IEP. Without these images we will not be able to progress your patient’s referral.

We cannot routinely accept out-of-area referrals for pressure sores, spinal infection or diabetic foot infection.

If any \* starred items are not completed the referral may not be processed.

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| **PATIENT DETAILS** | | | | | | | | | |
| NHS number: | | | | | | . | | | |
| \*Title: | \*Surname: | | | | | | \*Forenames(s): | | |
| \*D.O.B: | | | | \*Gender: | | | | | |
| \*Address: | | | | | | | | | |
| \*Postcode: | | | | | | | | | |
| Telephone (Home): | | | | | | | Telephone (Work): | | |
| Telephone (Mobile): | | | | | | | *\*Please give at least one contact number for the patient* | | |
| \*Patient has been resident in the UK for the last 12 months? | | | | | | | | *Yes* | *No* |
| \*Interpreter required? | | *Yes* | *No* | | *If yes, which language?* | | | | |
| Special/Mobility needs? *Is the patient on hospital transport?* | | | | | | | | | |
| **If your patient requires hospital or ambulance transport, this must be arranged by the referrer or the patient’s registered GP.** | | | | | | | | | |
| **ETHNIC BACKGROUND**  *\*Please tick one*  O White British O Pakistani  O White – Irish O Bangladeshi  O Any other white background O Any other Asian Background  O Mixed – White and Black Caribbean O Black Caribbean  O Mixed – White and Black African O Black African  O Mixed – White and Asian O Any other black background  O Any other mixed background O Chinese  O Indian O Any other ethnic group | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | |
| **\***Date of referral: | | | | | | | | | |
| \*Name: | | | | | | | | | |
| \*Responsible Consultant: | | | | | | | | | |
| \*Institution name: | | | | | | | | | |
| \*Address: | | | | | | | | | |
| \*Postcode: | | | | | | | | | |
| \*Hospital Telephone: \*Extension: | | | | | | | | | |
| \*Bleep/pager number: (Any member of the referring team) | | | | | | | | | |
| Referrer or consultant’s mobile number: (Not essential but may speed the referral process) | | | | | | | | | |
| **REPATRIATION AGREEMENT** | | | | | | | | | |
| \*Is the patient currently an inpatient at the referring hospital? Yes No  \*Are you requesting consideration of inter-hospital transfer? Yes No | | | | | | | | | |
| If YES to both questions, the referring consultant must sign below to indicate:   1. that they will accept the patient’s repatriation back to the referring hospital following assessment or treatment within 72 hours of our request. 2. that they have informed local operations / bed managers of this agreement   Consultant signature: ………………………… Date: ……………. | | | | | | | | | |
| **CLINICAL DETAILS** | | | | | | | | | |
| \*Comprehensive clinical details **AND** specific request / question(s) you’d like us to address (can be provided as separate referral letter) | | | | | | | | | |
| \*Please enclose full microbiology results from intraoperative or other relevant sample (eg positive B/C). Are there any infection control issues (eg: colonisation with MRSA, ESBL, VRE, CPE or other multi drug resistant organisms)? | | | | | | | | | |

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| **J BACH Classification**  **(This is a service development project relating to referrals: we’d be grateful if you could complete it)** |
| Using the table below, please classify the patient according to the following domains by highlighting ONE item in each of these 4 columns:     |  |  |  |  | | --- | --- | --- | --- | | Joint prosthesis **OR**  Bone infx | Antimicrobials | Soft tissue cover | Host | | J1 B1 | Ax / A1 | C1 | H1 | | J2 B2 | A2 | C2 | H2 | | J3 B3 | A3 | C3 | H3 | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Joint Specific**  **(PJI)** | **Bone Specific**  **(Osteomyelitis/FRI)** | **Antimicrobial options** | **Closure of Soft Tissues** | **Host Status** | | Uncomplicated | **J1**  PJI with all of the following:   * Primary implant *in situ* * Minimal bone loss * No evidence of loosening * No history of periprosthetic fracture | **B1**  Osteomyelitis with:   * Cavitary bone involvement (including cortical, medullary and non-segmental cortico-medullary) | **Ax**  Unknown/culture-negative  **A1**  All isolates:  Sensitive to >80% of susceptibility tests *and* resistant to <3 susceptibility tests | **C1**  Direct closure of soft tissues possible without plastic surgical intervention | **H1**  Well-controlled disease  *or*  Fit and well patient | | Complex | **J2**  PJI with either:   * Associated periprosthetic fracture * Moderate bone loss * Prosthetic loosening * Non-primary type implant *in situ* | **B2**  Osteomyelitis with:   * Segmental bone involvement (including infected non-union) * Joint involvement | **A2**  Any isolate:  Sensitive to <80% of all tests  *or*  Resistant to >4 tests  *or*  Resistant to anti-biofilm antibiotics in the presence of an implant | **C2**  Direct closure not possible. Plastic surgery expertise required. | **H2**  Poorly controlled disease  *or*  severe co-morbidity with  end organ damage  *or*  Recurrent bone infection/PJI  after previous treatment | | Limited options | **J3**  PJI with either:   * Custom or tumour type implant *in situ* * Custom or total bone replacement needed for reconstruction * Major bone loss | **B3**  Osteomyelitis with:   * Whole bone involvement | **A3**  Any isolate:  Sensitive to 0 *or* 1 susceptibility test | **C3**  More than one tissue transfer required for closure | **H3**  Unfit for definitive surgery  despite specialist intervention  or  Patient declines surgery | |