# **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@ouh.nhs.uk

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 PakistaniO White – Irish O BangladeshiO Any other white background O Any other Asian BackgroundO Mixed – White and Black Caribbean O Black CaribbeanO Mixed – White and Black African O Black AfricanO Mixed – White and Asian O Any other black background O Any other mixed background O ChineseO Indian O Any other ethnic group |
| **REFERRER DETAILS** |
| **\***Date of referral: |
| \*Name: |
| \*Responsible Consultant: |
| \*Institution name: |
| \*Address:\*Email 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)?****\*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.** |

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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 |

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| --- | --- | --- | --- | --- | --- |
|  | **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 interventionorPatient declines surgery |

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