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:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund ASAD as a standalone procedure 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 they wish to have surgery	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 sub-acromial decompression in isolation is not normally funded unless the patient has a massive sub-acromial spur scoring the muscle and may otherwise require a cuff repair.