

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.

Primary Care clinicians need to complete the checklist and submit with referral via eRS /  
 Secondary Care complete the checklist and file for future compliance audit.

The SY ICB will only fund ASAD as a standalone procedure when the following criteria are met:

| <i>In ordinary circumstances*, referral should not be considered unless the patient meets <b>ALL</b> of the following criteria.</i>                              | <b>Delete as appropriate</b> |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----|
| Patient has had symptoms for at least 3 months from the start of treatment <b>AND</b>                                                                            | Yes                          | No |
| Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) <b>AND</b>                                       | Yes                          | No |
| Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks <b>AND</b> | Yes                          | No |
| Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management <b>AND</b>          | Yes                          | No |
| Referral is at least 8 weeks following steroid injection <b>AND</b>                                                                                              | 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 SY ICB Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*