Acceptance Criteria for Northampton General Children's Physiotherapy Department:

These guidelines are designed to ensure appropriate referrals are accepted for our service and so that your child receives the right care.
(Please note we will contact the patient within 2 weeks of receiving their referral, however waiting list times for an appointment can be up to 18 weeks)

Acute Orthopaedic **Acute Musculoskeletal** **Acute Neurological conditions**	• Referrals must be made via the RMC from GPs or Consultants • Any MSK concerns raised by any other health professional must be referred via the child's GP	(<18 years old) • Juvenile idiopathic Arthritis (JIA) in flare up • EDS in flare up • Erbs palsy/ Talipes (within first 4 weeks) • Post BOT TOX • Post multi-level surgery • Orthopaedic surgery • Acute Head injury post discharge from ward (<8 years old) • Post fractures which have come out of plaster within past 2 weeks • Symptomatic Hypermobility (in flare up) • Acute soft tissue injuries (max of 4 weeks post injury) • Whiplash under 4 weeks duration
Musculoskeletal (MSK) Outpatients Clinic	• Children < 8 years old with an acute injury/ pain/ muscular concern • MSK/Orthopaedics – non acute JIA – not in flare up • Chronic Musculoskeletal • EDS – not in flare up	• MSK related pain e.g. Anterior knee pain/ Joint pain • Soft tissue injuries over 4 weeks duration • Back pain over 4 weeks duration • Symptomatic hypermobility • Gait disturbances (including tip toe walking) • Fractures once out of plaster for over 6 weeks • Torticollis/ Erbs palsy/ talipes (after first 2 months) • Normal orthopaedic variants (as indicated on the following pages)
Developmental Coordination Disorder (DCD) Clinic	• <8 years old • Schools must have completed schools pack prior to referral • Ongoing concerns both at home **AND** at school regarding balance and coordination	• Diagnosis of Dyspraxia/ DCD • With specific gross motor difficulties and reduced core stability

	• Referrals must be made via the RMC from School SENCo or Consultants	
Community Physiotherapy (Nursery/ School Setting)	• Age 2-16 • Children with specific school based needs • Referrals must be made via the RMC from GPs, Consultants, Allied Health Professionals or SENCO's	• Physical disabilities • Developmental Delay of physical skills • Cerebral Palsy, Muscular Dystrophy, Spina bifida, syndromes which result in physical disabilities • Children with significant gross motor delay (including pre-walking Downs Syndrome)
Special Schools	• Age 4-19 • Children with physio on EHCP • Referrals must be made via the RMC from GPs, Consultants, Allied Health Professionals or SENCO's	• Physical disabilities • Cerebral Palsy, Muscular Dystrophy, Spina bifida, syndromes which result in physical disabilities • Severe Developmental Delay of physical skills • Children with significant gross motor delay (including pre-walking Downs Syndrome) • Children with specific physiotherapy equipment needs
Under 2's/ CDC Assessment	• Age Birth- 2 years • Prematurity with complex birth history • Referrals must be made via the RMC from GPs, Health Professional or Consultants	• Physical disabilities • Cerebral Palsy, Muscular Dystrophy, Spina bifida, syndromes which result in physical disabilities • Developmental Delay of physical skills • Children with significant gross motor delay (including pre-walking Downs Syndrome)

Acceptance Criteria for Northampton General Children's Musculoskeletal (MSK) Outpatients Physiotherapy Department:

Normal variants of lower limb development such as flat feet, in toeing, out toeing, genu valgum (knock knees) and genu varum (bow legs), are a common source of parental concern but often do not require any intervention.

The following information is designed to help you identify when a referral is required, and which service is most appropriate to refer to.

Flat feet (Pes Planus)	Before the age of three all children have flat feet, as the arch on the inside of the foot does not begin to develop until after this age. The arches may 'appear' when a child is sitting, when the big toe is bent backwards or if a child stands on tiptoe. Even in older children flat feet do not usually cause any problems.	**Referral not necessary if:** • Asymptomatic • Flexible	Reassure parent/guardian and give APCP advice leaflet titled *"Flat Feet in Young Children"*	**Refer to Paediatric Physiotherapy if:** • Tightness into ankle dorsiflexion • Difficulty rising onto tip toes • Marked tripping and falling, affecting daily function • Pain in lower limbs **Refer to Paediatric Orthopaedics if:** • Arch of foot doesn't correct on tip toes in over 5's • Asymmetrical flat feet (especially with heel valgus) **Refer to Podiatry/Orthotics if:** • Over 5's with flexible feet and localised foot pain
Intoeing	Intoeing gait (walking with feet turning facing inwards) is a normal variant of developing gait and often resolves over time, therefore it is important that the child has a well-established gait (e.g. independent for at least six months) before assessment**.** In the first years of life it is usually due to metatarsus adductus. Internal tibial torsion is a normal variant up to seven years of age and may be symmetrical or	**Referral not necessary if:** Asymptomatic normal variants (up to eight years of age). Physiotherapy cannot prevent the tripping often associated with intoeing.	Reassure parents/carers and give APCP advice leaflet *"intoeing gait"*.	**Referral to Paediatric Physiotherapy if:** • Metatarsus adductus with true tightening of the medial structures of the foot and a medial crease. There may also be a curved lateral border of the foot. • Intoeing associated with hip, knee or foot pain. • Abnormal neurology e.g. abnormal tone (Referral to **Paediatrician** also indicated in this case). **Referral to Paediatric Orthopaedics if:** • Asymmetrical hip range or movement

	asymmetrical. Femoral anteversion is a normal variant up to 10 years of age and is generally symmetrical.			• Child over eight years of age with pain, tripping over, significant deformity causing psychological distress.
Genu Varum: (bow legs)	Genu varum is a normal variant up to the age of two and will normally change to valgus by the age of four. It can be associated with overweight babies/toddlers and early walkers.	**A Physiotherapy referral is <u>not necessary</u>.**		**Referral to Paediatric Orthopaedics if:** • Genu varum persists after two years or progressively worsens from 12-18months. Rickets and Blount's will need to be excluded) • Asymmetrical knee varus • Inter-condylar distance with the feet together of over 6cm in standing.
Genu Valgum: (knock knees)	Genu Valgum is a normal variant for children aged two to four years of age, and tends to revert to adult alignment by six to eight years of age.	**A Physiotherapy referral is <u>not necessary</u>.**		**Referral to Paediatric Orthopaedics if:** • Asymmetrical knee valgus • Excessive or worsening valgus knees after six years of age • Inter-malleolar distance of over 8cm in standing.
Outoeing:	This is also a normal variant, although less common than intoeing, and should be assessed when walking is well-established (e.g. independent for at least six months). It is often associated with knock knees and flat feet. It can be caused by external femoral torsion, external tibial torsion or marked calcaneo-valgus. There are a number of differential diagnoses that may present with an out-toeing gait (e.g. Perthes, DDH, SUFE).	**Referral not necessary if:** Symmetrical out-toeing that is asymptomatic		**Referral to A&E if:** • Sudden onset out toeing following trauma • Sudden onset of unilateral out toeing **Referral to Paediatric Physiotherapy if:** • Symmetrical out toeing associated with pain in lower limbs **Referral to Paediatric Orthopaedics if:** • Asymmetrical hip movements • Persistent pain despite intervention
Pes Cavus:	This is where the arch of the foot is very pronounced (the opposite of a flat foot). This is rare but likely to be related to a neurological pathology. The child should therefore be screened by a Paediatrician or Orthopaedic Consultant.	**A physiotherapy referral is <u>not necessary</u>.**		

Curly toes:	Congenital curly toes tend to affect 3rd, 4th and 5th toes of one or both feet and tend to become more noticeable when a child starts walking. They are often flexible and are as a result of intra-uterine moulding. They generally do not cause any gait problems. If the overriding toes are flexible/correctable, no treatment or referral is indicated. The GP or Health Visitor can show stretches to extend the toes if they are a little tight. This can be advised after a bath. The aim of this is to maintain or improve flexibility.	**A Physiotherapy referral is <u>not necessary</u>.**		**Referral to Paediatric Orthopaedics if:** Ongoing significant problems such as blisters, pain, excessive tightness in tendons • 2nd or 3rd toes deviate medially or laterally at distal IP joint

Useful advice leaflets available from APCP website (apcp.csp.org.uk) include:
APCP 'Paediatric MSK Warning Signs' (Information leaflet for professionals)
APCP 'Intoeing Gait' (Parent information leaflet)
APCP 'Flat Feet in Young Children' (Parent information leaflet)
APCP 'Choosing footwear for Children' (Parent information leaflet)