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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TONSILLECTOMY IN ADULTS & CHILDREN** | | | | | | | | | | | |
| **PRIOR APPROVAL REQUIRED** | | | | | | | | | | | |
| **A. Patient Information** | | | | | | | | | | | |
| **Name** |  | | | | | | | Male |  | Female |  |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Date of Birth** |  | | **NHS Number** | | | | |  | | | |
| **B. Referrer’s Details (GP / Consultant / Clinician)** | | | | | | | | | | | |
| **Name** |  | | | | | | | **Patient requested referral** | | | |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Telephone** |  | | | **Email** | |  | | | | | |
| **GP Details (if not referrer)** | | | | | | | | | | | |
| **Name** |  | **Practice** | | | | |  | | | | |
| By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete and that you have:   * Discussed all alternatives to this intervention with the patient * Had a conversation with the patient about the most significant benefits and risks of this intervention – Where appropriate * Informed the patient that this intervention is only funded where criteria are met, or exceptionality demonstrated * Checked that the patient is happy to receive postal correspondence concerning their application where appropriate, or clarified alternative needs * Checked that the patient understands spoken and written English, or clarified required needs   I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or a legitimate representative of the patient) prior to disclosure of their personal details for the purpose of a panel / IFR team to decide whether this application will be accepted, and treatment funded. By submitting this form, I confirm that the patient / representative has been informed of the details that will be shared for the purpose and consent has been given. | | | | | | | | | | | |
| **Signed (referrer)** | | | | | **Date** | | | | | | |
| **Submission**  The completed form(s) should be sent electronically (from an *nhs.net* email address) in confidence with any other supporting documents to the appropriate email address: [BSWICB.EFR@nhs.net](mailto:BSWICB.EFR@nhs.net)  **To comply with information governance standards, emails containing identifiable patient data should only be sent securely, i.e., from an *nhs.net* account.** | | | | | | | | | | | |

**THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

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| **C. Clinical Criteria - to be read in conjunction with the Tonsillectomy Policy** | | | | |
| **CLINICAL CRITERIA FOR SURGERY** | | | | |
| Sore throats are due to acute tonsillitis | | | | Choose an item. |
| * **AND seven** or more well documented, clinically significant, treated sore throats in **one** year | | | | Choose an item. |
| * **OR five** or more such episodes in **each** of the preceding **two** years | | | | Choose an item. |
| * **OR three** or more such episode in **each** of the preceding **three** years | | | | Choose an item. |
| **Dates of documented episodes of Tonsillitis**: |  |  | |  |
|  |  |  | |  |
| **OR** | | | | |
| Has evidence of persistent and significant Obstructive Sleep Apnoea (OSA) been demonstrated?  Obstructive Sleep Apnoea in children should be diagnosed clinically: | | | | Choose an item. |
| * A history of witnessed sleep apnoeic attacks in the presence of snoring. | | | | Choose an item. |
| * **AND** The presence of large and obstructive tonsils | | | | Choose an item. |
| * **AND** Failure to thrive (documented impact on development, behaviour and quality of life, height and weight, hyperactivity, daytime somnolence) | | | | Choose an item. |
| * **AND** Absence of any neurological deficit which might cause Central Sleep Apnoea. | | | | Choose an item. |
| *(A sleep study i.e., polysomnography is not required for the diagnosis of Obstructive Sleep Apnoea in children.)*  ***Of note*** *- children with simple snoring without symptoms or signs of Apnoea are unlikely to benefit from adenotonsillectomy.* | | | | |
| **Obstructive sleep apnoea/hypopnoea syndrome in adults**:  NICE guidance recommends that tonsillectomy may be considered for people with OSAHS who:  **•** Have large obstructive tonsils | | | Choose an item. | |
| **• AND** A body mass index (BMI) of less than 35 kg/m2 | | | Choose an item. | |
| ***Tonsillectomy procedures are not normally commissioned by the ICB for tonsil stones or halitosis alone and would require an exceptional funding request to be submitted.***  **Fast track referral for specialist assessment and investigation for malignancy (which may include tonsillectomy for biopsy) is not restricted by this policy and does not require prior approval.** | | | | |
| **Mitigating circumstances/reasons for applying if policy criteria are not met, please document the evidence you are enclosing to support this request.** | | | | |