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| **BLEPHAROPLASTY & PTOSIS SURGERY (18 & OVER)** |
| **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/EFR 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 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 Blepharoplasty & Ptosis Surgery Policy** |

**Right:** Choose an item. **Left:** Choose an item. **Bilateral:** Choose an item.

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| **CLINICAL CRITERIA FOR SURGERY** |
| **Blepharoplasty and Ptosis surgery**. This procedure is not routinely funded and will only be considered for prior approval when there is: |
| * Evidence of significant functional impairment\*
 | Choose an item. |
| * Drooping of the tissue above the eyelid causes persistent impairment of visual fields in the relaxed, non-compensated state
 | Choose an item. |
| * Documented evidence of encroachment of the central 20 degrees of visual field
 | Choose an item. |
|  **AND** |
| * Surgery will improve the vision of the patient
 | Choose an item. |
| Supporting evidence in the form of photographs and an appropriate visual field test result will be required. (The ICB will NOT reimburse the costs of medical photography.)Visual Fields included: Choose an item. Photographs included: Choose an item.Visual fields can be conducted by local optometrists as part of an eye test.  |
| What is the patient unable to do because of their condition? |
| Is the patient unable to fulfil any work / study / carer essential activities and if so to what extent? |
| * Supporting information must be provided with the application (please document the evidence you are enclosing to support this request).
* To enable the ICB to approve individual cases, information with examples of functional impairment using the guidance below should be provided.
* The patient is also welcomed to provide a statement, to include examples of significant functional impairment.
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| **Significant functional impairment is defined as:** *Symptoms preventing the patient fulfilling activities of daily living or conducting vital domestic or carer activities.* |
| ***Smoking cessation is recommended for all patients considering the possibility of surgery.*** |