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| **DUPUYTRENS SURGERY** | | | | | | | | | |
| **PRIOR APPROVAL REQUIRED** | | | | | | | | | |
| 1. **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 * 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 * Checked that the patient understands spoken and written English   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 ……………………………………………………. Dated: …………………………………………………… | | | | | | | | | |
| **Submission**  The completed form(s) should be sent electronically (from a nhs.net email address) in confidence with any other supporting documents to [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 FOR SURGERY** | |
| **Right Hand** Choose an item. **Left Hand** Choose an item. **Bilateral:** Choose an item. | |
| All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient’s life. However, none cure the condition which can recur in operated digits or in previously uninvolved areas of the hand. Recurrence is more likely in younger patients; if the original contracture was severe; or if there is a strong family history of the condition.  After surgery, the hand may be fitted with a splint to be worn at night. Hand therapy is important in recovering movement and function, especially for more extensive surgery and skin grafts. (The British Society for Surgery of the Hand) | |
| **\*Significant functional impairment is defined as symptoms preventing the patient fulfilling vital work or educational activities or carrying out vital domestic or carer activities** | |
| **Treatment is not indicated in cases where there is no contracture and in patients with mild (less than 30 degree) contractures, or one which is not progressing and does not impair function.** | |
| **Funding will be available for treatment when:**   * The patient has a ≥30-degree fixed flexion deformity at either the metacarpophalangeal joint or proximal interphalangeal joint or a severe thumb contracture.   **AND**   * The patient has significant functional impairment\*.   **OR**   * There has been rapid progression over a few months. | **Yes  No**    **Yes**  **No**  **Yes  No** |
| **Please provide images to support the application.**  The ICB will accept patients own photographs but will **NOT** reimburse the cost of medical photography.  **Photographs attached** | |
| **\*Supporting information must be provided with the application:** Information with examples of functional impairment should be provided. Panel members welcome patient statements. | |
| What is the patient unable to do because of their condition? Is the patient unable to fulfil any vital work/educational activities? Is the patient unable to carry out essential domestic/carer activities? What is the degree of pain and any related medication? | |