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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Ganglia** | | | | | | | | | | | |
| **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 Ganglion Policy** |

There is a reasonable chance that ganglia will disappear spontaneously and even if they persist, they do not cause adverse long-term effects.

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| **Commissioners will ONLY consider requests for treatment of Ganglion where there is evidence of:** |
| * Significant functional impairment which prevents the individual from fulfilling work / study / carer or domestic responsibilities.   **OR**   * Malignant in nature - refer your patient via the two weeks wait referral route. |
| **CLINICAL CRITERIA FOR SURGERY** |

|  |  |  |
| --- | --- | --- |
| Precise location of ganglion e.g., flexor tendon? | **Right**: Choose an item. **Left**: Choose an item. | |
| Size in cm/inches (lenfth and width)? |  | |
| How long has ganglion been present and what treatments have been tried? |  | |
| How is function impaired?  What is the patient unable to do? |  | |
| Degree of pain and the treatment of this? |  | |
| Impact on work / studies / care i.e., is the patient unable to fulfil any essential activities such as cooking & washing |  | |
| **Has aspiration been attempted?**  At least two aspiration attempts should be made prior to a surgical intervention request.  **Please provide dates of treatment** | Choose an item. | |
| **Date of first aspiration** | **Date of second aspiration** |
|  |  |
| * **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 welcome to provide a statement, to include examples of significant functional impairment.** * **You may provide photographs if appropriate as supporting evidence. The ICB will accept patients own photographs and will NOT reimburse the costs of medical photography.** | | | |
| **Significant functional impairment is defined as:** *Symptoms preventing the patient fulfilling activities of daily living or carrying out vital domestic or carer activities.* | | | |