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| **BUNIONS - SURGICAL REFERRAL** | | | | | | | | | | | |
| **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 Bunion Surgery Policy** |

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

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| **CLINICAL CRITERIA FOR SURGERY** | |
| * **Significant functional impairment is defined as:** *symptoms preventing the patient fulfilling activities of daily living or conducting vital domestic or carer activities.* | |
| **Have the following been employed:** | |
| * Conservative management techniques have been employed for a minimum of 12 months. | Choose an item. |
| * Avoiding high heeled shoes and wearing wide fitting shoes that stretch | Choose an item. |
| * Exercises specifically designed to alleviate the effects of a bunion and keep it flexible | Choose an item. |
| * Applying ice and elevating painful and swollen bunions | Choose an item. |
| * Non-surgical treatments such as bunion pads, insoles, and orthotics to relieve pain (over the counter products) | Choose an item. |
| **The ICB will only consider requests for the surgical correction of symptomatic bunions**  **if the following criteria are met:** | |
| * The patient suffers from severe and persistent pain and deformity that causes significant functional impairment despite following the above advice. | Choose an item. |
| **OR** | |
| * There is a higher risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. | Choose an item. |
| * **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.** * **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.** | |
| 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 conduct essential domestic / carer activities? | |
| What is the degree of pain and any related medication? | |
| ***Smoking cessation is recommended for all patients considering the possibility of surgery.*** | |