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| **CHALAZION EXCISION** |
| **PRIOR APPROVAL REQUIRED Including REFERRALS to a GPwER** |
| **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. |
| **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.**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 Chalazion excision Policy** |

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

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| **CLINICAL CRITERIA FOR CHALAZION EXCISION** |
| Where a General Practitioner with Extended Role (GPwER) is available, the procedure will not normally be funded in secondary care. GPwERs may subsequently refer onto secondary care without Prior Approval should it be considered appropriate. |
| **Prior approval is required.**The ICB will only consider funding excision of a chalazia when the following criteria are met. |
| * The chalazia has been present for more than 6 months verified in clinical notes.
 | Choose an item. |
| * Has been managed conservatively with heat, lid cleaning and massage for four weeks
 | Choose an item. |
| * Where it is present on the upper eyelid, and interferes significantly with vision
 | Choose an item. |
| * Where it is a source of regular infection that has required medical attention twice or more within a six-month period
 | Choose an item. |
| **In common with all types of lesions, the ICB will fund removal where malignancy is suspected.** |
| * **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 the following 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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| ***Smoking cessation is recommended for all patients considering the possibility of a procedure.*** |