|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BOTULINUM TOXIN A FOR THE MANAGEMENT OF**  **ANAL FISSURE IN ADULTS** | | | | | | | | | | |
| **CRITERIA BASED ACCESS FOR**  **FIRST TREATMENT** | | **PRIOR APPROVAL REQUIRED FOR FURTHER TREATMENTS** | | | | | | | | |
| **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 a *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** | | | | | | | | | | |

**Application to be submitted by Secondary Care**

**THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

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| **C Clinical Criteria - to be read in conjunction with the Botulinum Toxin A Policy** | |
| **CLINICAL CRITERIA FOR FUNDING BOTULINUM TOXIN A**  **FOR THE MANAGEMENT OF ANAL FISSURE IN ADULTS** | |
| **Management of anal fissure in adults:**   * **Criteria Based Access for first treatment.** * **Prior Approval is required for any subsequent treatment.** | |
| **First line treatment-trial for 6-8 weeks**   * Bulk fibre supplements | Choose an item. |
| * Glyceryl trinitrate (GTN 0.2% ointment) | Choose an item. |
|  | |
| **Second line treatment**   * Diltiazem 2% cream (unlicensed) | Choose an item. |
| **Date of first Botox injection administered:** |  |
| **Please give clinical reasons for requesting a second Botox injection:** | |