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| **SKIN LESION REMOVAL** | | | | | | | | | | |
| **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: …………………………………………………………. Date: ……………………………………… | | | | | | | | | | |
| **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**

**C. Clinical Criteria to be read in conjunction with the “Skin Lesion” Policy**

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| **CLINICAL CRITERIA FOR SURGERY** | | | | | |
| **\*Significant functional impairment is defined as symptoms preventing the patient fulfilling vital work or educational activities or conducting vital domestic or carer activities** | | | | | |
| **Removal of benign skin lesions cannot be offered for cosmetic reasons. Removal should only be offered in situations where the lesion is causing symptoms according to the criteria outlined below. Surgery to improve appearance alone is not provided for normal changes such as those associated with aging.** | | | | | |
| If the GP Practice or PCN are unable to remove the skin lesion, **PRIOR APPROVAL** will be required for onward referral.  Requests for the removal of benign skin lesion will be considered for funding for the following:   * Sebaceous cysts where there has been more two or more documented episode of infection, which have required two or more courses of antibiotics | | | | | **Yes  No**        **Yes  No**  **Yes  No** |
| Dates ABX Prescribed: |  |  | |  |
| **OR**   * Lesions which cause significant functional impairment\*   **OR**   * Lesions on the face where the extent and size of the lesion can be regarded as disfigurement.   Please provide images to support the application.  The ICB will accept patients own photographs but will **NOT** reimburse the cost of medical photography. | | | | |
| **Type of lesion:** | | | **Location:** | | |
| **Size:** | | | **Photographs attached Yes** | | |
| **BCC Yes  Please refer to the BCC policy statement.** | | | | | |
| **\*Supporting information must be provided with the application:** Information with examples of functional impairment should be provided. Please provide photographs as supporting evidence. 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 conduct essential domestic/carer activities? What is the degree of pain and any related medication? | | | | | |