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| **THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**STRICTLY PRIVATE AND CONFIDENTIAL APPLICATION FOR **PRIOR APPROVAL** | **Nature of proposed treatment or intervention:** |
| **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 the 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, 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)** | **Print name** |
| **Date** |  |
| **SUBMISSION**The completed form(s) should be sent electronically (from an *nhs.net* email address) in confidence with any other supporting documents to 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.** |

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| **C Clinical Criteria** |

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

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| **Nature of proposed treatment or intervention:** |
| **Please supply the background to your patient’s care to date and your rationale to support the use of this treatment in place of any standard care available:** |
| * 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 the patient’s own photographs and will NOT reimburse the costs of medical photography.
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| **Significant functional impairment is defined as:**Symptoms preventing the patient fulfilling activities of daily living or carrying out vital domestic or carer activities. |