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| **SPINAL PAIN: NECK AND LOWER BACK PAIN** | | | | | | | | | | | |
| **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 * 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 spinal pain: neck and lower back pain policy** | |
| This applies to all policy related spinal injections irrespective of the specialty providing the service. Prior Approval funding is required as set out below. Locally agreed tariffs apply. On referral to the pain pathway model patients must be informed that the referral is for assessment and development of a pain management plan. Patients will not necessarily be offered an injection or surgery. | |
| **Repeat Epidural/Nerve Root Injections** **(More than 2)** | |
| * Evidence that the patient has had a minimum of 6 months pain relief and functional improvement. | Choose an item. |
| **Repeat Radiofrequency Denervation** | |
| Evidence that the patient has reported significant improvement in pain relief and function at 16 months post initial denervation procedure. | Choose an item. |
| **Lumbar Discectomy Surgery**  Discectomy surgery is only commissioned in adult patients who meet the following criteria: | |
| * The patient has had MRI showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms.   **AND**   * The patient has radicular pain (below the knee for lower lumbar herniation’s, into the anterior thigh for upper lumbar herniation’s) consistent with the level of spinal involvement.   **OR**   * There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)   **AND**   * Symptoms persist despite non-operative treatment for at least 3 months (e.g., analgesia, physical therapy, bed rest) except in severe cases and if analgesia is adequate and there is no imminent risk of neurological deficit. | Choose an item.  Choose an item.  Choose an item.  .Choose an item. |
| Patients who are not eligible for treatment under this policy may be considered on an individual basis, if their consultant believes there are exceptional circumstances that warrant deviation from the rule of this policy. Applications to be made via the Exceptional funding route including details to show why alternative treatments cannot be sought and what treatment has already been tried. | |
| **Significant functional impairment is defined as:** *Symptoms preventing the patient fulfilling activities of daily living or conducting vital domestic or carer activities.*  ***Smoking cessation is recommended for all patients considering the possibility of a procedure.*** | |