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| **CHALAZIA TREATMENT** | | | | | | | | |
| **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](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 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.  When referring from primary care for chalazion, please add a photograph of the chalazion with the referral. BSW ICB will accept patients own photographs and will **NOT** reimburse the costs of medical photography. | | |
| **Prior approval is required.**  Chalazia (meibomian cysts) are benign lesions that will normally resolve within six months with conservative management (see below).  Subject to the criteria stated below, BSW ICB will fund incision and curettage (or triamcinolone injection for suitable candidates) of chalazia where: | | |
| * The chalazion has been present for more than 6 months   **AND**  The chalazion has been managed conservatively for four weeks\*  **AND**   * Where it is a source of regular infection that has required medical attention twice or more within a six-month period   **OR**   * The chalazion prevents closure of the eyelid | | Choose an item.  Choose an item.  Choose an item.  Choose an item. |
| * Please provide dates of when medical attention was required within a six-month period |  |  |
| **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).** | | |
| ***CONSERVATIVE MANAGEMENT:***  *Conservative management of chalazia involves the application of a warm compress (for example using a clean flannel that has been rinsed with hot water) to the affected eye for 10-15 minutes, after which the cyst should be gently massaged (to aid expression of its contents) in the direction of the eyelashes using clean fingers or cotton buds. This should be repeated up to five times a day for several weeks.*  *Antibiotic treatment is not recommended for a chalazion.* | | |
| ***Smoking cessation is recommended for all patients considering the possibility of a procedure.*** | | |