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| **CARPAL TUNNEL SURGERY** |
| **PRIOR APPROVAL REQUIRED FOR ALL PROVIDERS** |
| **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.**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 Carpal Tunnel Surgery Policy** |

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

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| **CLINICAL CRITERIA FOR SURGERY** |
| Carpal tunnel syndrome is a common condition that affects the nerves of the hand causing pain, numbness and a burning or tingling sensation in the hand and fingers. Symptoms can be intermittent and range from mild to severe. Patients with intermittent or mild/moderate symptoms should be managed conservatively in the first instance. |
| **Referral criteria:** |
| * There is neurological deficit, e.g., sensory blunting, muscle wasting or weakness of thenar abduction.
 | Choose an item. |
| **OR** |  |
| * The patient is experiencing significant functional impairment
 | Choose an item. |
| **AND** |  |
| * Symptoms persist despite at least four months conservative therapy with at least one local corticosteroid injection administered in primary care and nocturnal splinting.
 | Choose an item. |
| **Dates of corticosteroid injections administered:** |  |  |
| **Please give detailed evidence to support functional impairment:** |
| 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 welcome to provide a statement, to include examples of significant functional impairment. |
| **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.*** |