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CATEGORY	Bristol	Prior Approval
	North Somerset	Prior Approval
	South Gloucestershire	Prior Approval



APPLICATION FOR PRIOR APPROVAL FOR FUNDING

Removal of Bunions / Lesser Toe Deformity

STRICTLY PRIVATE AND CONFIDENTIAL

PART A: THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS

PATIENT INFORMATION							
Does this case need to be reviewed urgently due to clinical need? <i>If yes, please explain</i>	<input type="checkbox"/> YES	<i>(i.e. What is the window of opportunity and the timescale required for optimum treatment?)</i>					
	<input type="checkbox"/> NO						
Name				Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
Address							
Post Code							
Date of Birth			NHS Number				
Does the patient understand spoken and written English?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>			
Please tick if the patient agrees to receive communication by letter	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>			
Patient Consent: The Patient hereby gives consent for disclosure of information relevant to their case from professionals involved and to the Panel.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>			
Referrer's Details (GP/Consultant/Clinician):							
Name							
Address							
Post Code							
Telephone			Email				
GP Details (if not referrer):							
Name			Practice				
Referrer please confirm:							
<input type="checkbox"/> I have discussed all alternatives to this intervention with the patient.							
<input type="checkbox"/> I have advised the patient of any side effects and risks of this intervention, and if appropriate used a 'Decision Making Aid'							
<input type="checkbox"/> I have informed the patient that this intervention is only funded where criteria are met							
<input type="checkbox"/> I have informed the GP of this application for funding (if not GP request)							
Signed Referrer:							
Date:							
PLEASE NOTE REGISTRARS/LOCUMS WILL NEED TO GAIN APPROVAL FROM A SENIOR CLINICIAN BEFORE PROCESSING THIS REQUEST. ANY REQUESTS NOT COUNTERSIGNED BY A SENIOR CLINICIAN WILL BE RETURNED.							

PART B: THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS

If your patient does not meet the following criteria then please ALSO fill out Part C of this form outlining the patient's exceptionality. If the criteria are met you only need complete Parts A and B.

<p>1. Have conservative management techniques* failed?</p> <p>*Conservative management techniques include:</p> <ul style="list-style-type: none"> • Avoiding high heel shoes and wearing wide fitting leather shoes which stretch • Exercises specifically designed to alleviate the effects of a bunion and keep it flexible. • Applying ice and elevating painful and swollen bunions • Non-surgical treatments such as bunion pads, splints, insoles or shields <p>AND</p> <p>2. Does the patient suffer from severe deformity (overriding toes) that causes significant functional impairment**?</p> <p>OR</p> <p>3. Does the patient suffer from severe pain that causes significant functional impairment**?</p> <p><i>** Significant functional impairment is defined by the BNSSG Health Community as:</i></p> <ul style="list-style-type: none"> - Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities 	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
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Please enclose evidence below to support the information you have provided, particularly which conservative management techniques have failed. Without evidence this application will be rejected. Supporting Information - You may submit photographs if appropriate as supporting evidence.

<p>Supporting Information Please document the evidence you are enclosing along with any other information that you feel is relevant</p>	
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FOR PCT COMPLETION ONLY

<p>Approved / Refused</p>	<p>Signed:</p>
	<p>Title:</p>

PLEASE SEND THIS FORM TO THE PCT IF THE ABOVE CRITERIA ARE FULLY MET AND EVIDENCED. IF NOT, PLEASE GO ON TO COMPLETE PART C.

PART C: EXCEPTIONAL FUNDING

ONLY COMPLETE IF PATIENT DOES NOT MEET THE CRITERIA IN PART B

Exceptionality	<i>Please note that not meeting the criteria is not in itself exceptional. Additional exceptionalities should be demonstrated. The sections below must be completed, otherwise the application will not be taken further.</i>	
Explain why the patient is significantly different to the general population of patients with the condition in question		
Explain why the patient is likely to benefit more from the intervention than might normally be expected for patients with that condition		
Brief and relevant health history, including patient's current health status and any other co-morbidities, health issues and current medication.		
Clinical History relevant to the case		
What treatments has the patient tried? Is this patient unable to tolerate the usual care? What services has the patient been referred to?		
<i>The patient is welcome to provide a statement and photographs to support this application if they wish.</i>		
The completed form should be sent in confidence with any other supporting documents to:		
NHS North Somerset: Individual Commissioning Panel Waverley House Old Church Road Clevedon BS21 6NN icprequests@nhs.net	NHS Bristol: Exceptional Funding Team South Plaza Marlborough Street Bristol BS1 3NX exceptionalfunding@nhs.net	NHS South Gloucestershire: Exceptional Funding Team 8 Brook Office Park Folly Brook Road Emersons Green South Gloucestershire BS16 7FL exceptionalfunding.sglospct@nhs.net
In order to comply with information governance standards, emails containing identifiable patient data should only be sent securely, i.e. from an nhs.net account		