**Non Cosmetic Nasal Treatment and Sinusitis**

**Application for Prior Approval of Funding**

**STRICTLY PRIVATE AND CONFIDENTIAL**

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| **PATIENT INFORMATION** | | | | | | | | | | | |
| **Name** |  | | | | | | | **Male** |  | **Female** |  |
| **Address**  **Post Code** |  | | | | | | | | | | |
| **Date of Birth** |  | | | **NHS Number** | | | |  | | | |
| **Referrer’s Details (GP/Consultant/Clinician):** | | | | | | | | | | | |
| **Name** |  | | | | | | | | | | |
| **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 you confirm (please clarify in the box below) 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.** * **Checked that the patient is happy to receive postal correspondence concerning their application.** * **Discussed with the patient whether any additional communication requirements (e.g. different language, format or limited capacity) are needed (please specify requirements in the box below).**   ***ANY REQUESTS NOT COUNTERSIGNED BY A SENIOR CLINICIAN/Salaried***  ***or Partner GP WILL BE RETURNED.***   |  | | --- | | **Clarification/Communication 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/EFR 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 aforementioned purpose and consent has been given.**  ***SIGNED REFERRER: ………………………………….….………………… DATE: …………………..*** | | | | | | | | | | | |

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| **NOTE: This policy does not apply to immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and does not require prior approval from the ICB.** | |
| **Septoplasty/Septorhinoplasty**  Requests for corrective nasal surgery will be considered where:   1. The patient has:    1. A Post-traumatic nasal injury causing bilateral, continuous and chronic nasal airway obstruction associated with septal/bony deviation of the nose.   **OR**   * 1. Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity.   **OR**   * 1. Documented physical clinical problems caused by bilateral obstruction of the nasal airway andall conservative treatments have been exhausted.   **Note:** Patients with acute nasal trauma within the last two weeks can be referred to ENT hot clinic or be seen following referral from ED. | **YES**  **NO**  **YES  NO**  **YES  NO** |
| **Chronic Rhino-sinusitis – CRS**  Funding Approval for referral for assessment in secondary care will only be provided by the ICB for patients meeting criteria set out below and are fully documented within the patient’s primary care records.  Primary Care – (The following is required for referral to secondary care)  **2.**   1. The patient has typical symptoms, and a clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance – i.e. the presence of nasal blockage (obstruction/congestion) or nasal discharge (anterior/posterior nasal drip) with facial pain or pressure (or headache) and/or reduction (or loss) of the sense of smell, lasting for longer than 12 weeks without complete resolution)   **AND**   1. The patient still has moderate/severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation. (See the [Nasal Treatment](https://remedy.bnssgccg.nhs.uk/adults/ent/nasal-treatment/) page on Remedy for further advice.) Please document details of treatments tried.   **OR**   1. The patient has bilateral nasal polyps **and** symptoms of CRS and there has been no improvement in symptoms after a trial of 5-10 days of oral steroids (prednisolone 0.5mg/kg to a max of 60 mg) followed by 4 weeks of topical steroid drops (see the [Nasal Treatment](https://remedy.bnssgccg.nhs.uk/adults/ent/nasal-treatment/) page on Remedy for further advice)..   **OR**   1. Patient has nasal symptoms that are atypical and therefore there are concerns about the diagnosis (please initially see the [Nasal Treatment page](https://remedy.bnssgccg.nhs.uk/adults/ent/nasal-treatment/) on Remedy for further advice). These symptoms have been clearly documented in the patient’s primary care records. | **YES  NO**  **YES  NO**  **YES  NO**  **YES  NO** |
| **Note:**  Patients who have Obstructive Sleep Apnoea due to bilateral nasal obstruction can be referred direct without Prior Approval from the Sleep Apnoea Service. | |

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| **Funding will be declined if a copy of the patient’s clinical records evidencing the above is not submitted with the application.** | |
| **BNSSG Practices supported by RS**  **Applications are to be attached to referrals and sent to RS via e-RS pathway.**  **If for some reason you are unable to send your application this way, please contact the Referral Service for guidance.** | **BNSSG Practices not supported by RS**  **By email to:** [**BNSSG.Referral.Service@nhs.net**](mailto:BNSSG.Referral.Service@nhs.net)  **If for some reason you are unable to send your application via email, please contact the Referral Service for guidance.** |
| **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.** | |