**EXOGEN ULTRASOUND BONE HEALING SYSTEM**

**Application for Prior Approval for 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.***

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| **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: Please refer to the exclusions detailed in the policy, where the clinical evidence reviewed by NICE does not support the provision of EXOGEN.** |
| 1. To treat long bone fractures of the [femora](http://en.wikipedia.org/wiki/Femur), [tibiae](http://en.wikipedia.org/wiki/Tibia) and [fibulae](http://en.wikipedia.org/wiki/Fibula) of the legs or the [humer](http://en.wikipedia.org/wiki/Humerus)us, [radi](http://en.wikipedia.org/wiki/Radius_%28bone%29)us and [ulnae](http://en.wikipedia.org/wiki/Ulna) of the arms with non-union, defined as failure to heal after 9 months.

 **AND**1. Surgery will be required to correct the non-union of the long bone fracture. This includes primary and revision surgery where primary surgery has failed.

 **AND**1. The patient would be eligible, fit and appropriate for surgery to correct the non-union.

 **AND**1. Patients must be able and willing to fully comply with the treatment regime of administering the device for 20 minutes per days for a minimum of 120 days either through self-management or with the help of carers.
 | **YES** **[ ]  NO** **[ ]** **YES** **[ ]  NO** **[ ]** **YES** **[ ]  NO** **[ ]** **YES** **[ ]  NO** **[ ]**  |

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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.** |
| **North Somerset Area****By email to:** **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.** | **Bristol / South Gloucestershire Areas****By email to:** **BNSSG.IFR@nhs.net****If for some reason you are unable to send your application via email, please contact the IFR Team 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.** |