**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 CCG.** | |
| **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 CCG 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)  **1.**   1. A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate/severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation.   **AND**   1. In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (prednisolone 0.5mg/kg to a max of 60 mg).   **OR**   1. Patient has nasal symptoms that are atypical or 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). | **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.** | |
| **North Somerset Area**  **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.** | **Bristol / South Gloucestershire Areas**  **By email to:** [**BNSSG.IFR@nhs.net**](mailto:BNSSG.IFR@nhs.net)  **If for some reason you are unable to send your application via email, please contact the EFR 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.** | |