**Syndactyly (SURGICAL CORRECTION OF THE FINGERS)**

**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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| **Surgical treatment of syndactyly of the fingers or toes is not routinely funded**  **by the CCG. This policy only considers those affecting fingers.** | | | |
| Funding approval will be provided by the CCG where the patient is suffering from:  Type 4 or Type 5: Haas-type Polysyndactyly of either one or both hands.  **AND**   1. Permanently flexed fingers and/or a cup shaped hand due to Polysyndactyly. | | | **YES**  **NO**  **YES  NO** |
| ***Please provide evidence below to support the information you have provided, particularly which advice and support has been unsuccessful.***  ***Without evidence this application will be rejected*** | | | |
| **Supporting**  **Information** |  | | |
| **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.** | | | |