**GROMMETS – REFERRAL FOR CHILDREN UNDER 16YRS**

**WITH RECURRENT ACUTE OTITIS MEDIA**

**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.***   |  | | --- | | **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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| **Emergency admission for rare serious complications of AOM are not restricted by this policy.**  The Commissioner will agree to fund a surgical referral for children with recurrent acute otitis media to include consideration of insertion of grommets, where the following criteria have been met:   1. The child has had at least 3 recurrences of acute otitis media in the previous 6 months or more than 4 recurrences in the previous 12 months, documented in primary care records.   **OR**   1. Has the child had an episode of AOM associated with any of the following: 2. intracranial infection? 3. acute mastoiditis? 4. facial paralysis? 5. neck abcess? | **YES**  **NO**  **YES**  **NO** |

|  |  |
| --- | --- |
| **To enable the CCG to approve individual cases the following information with dates the patient attended practice for treatment of AOM should be provided:** | |
| Dates of appointments with GP | **1.**  **2.**  **3.**  **4.** |
|  |  |
| **Supporting**  **Information** |  |

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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 via email, 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.** | |