**Ganglion Removal**

**Application for Prior Approval for Funding**

**STRICTLY PRIVATE AND CONFIDENTIAL**

**PART A: THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

|  |  |  |  |  |  |  |  |  |
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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.** * **Advised the patient that NHS Decision Making Aids are available online should the patient wish to access them at** [**http://sdm.rightcare.nhs.uk/pda/**](http://sdm.rightcare.nhs.uk/pda/) * **Informed the patient that this intervention is only funded where criteria are met or exceptionality demonstrated.** * **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/IFR 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: …………………...*** | | | | | | | | |

**PART B: THIS PAGE MUST BE COMPLETED FOR ALL REQUESTS**

***If your patient does not meet the following criteria then please ALSO fill out Part C of this form outlining***

***the patient’s exceptionality. If the criteria are met you only need complete Parts A and B.***

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| **NOTE: If there is uncertainty on whether the lesion may be malignant in nature, patient should be referred via the 2 week wait route. Funding approval is NOT required.** | |
| **Section A – Ganglion Removal**  Funding for referral to secondary care for radiology for guided injection/aspiration or for surgical excision will be considered where the patient meets all the following criteria:   1. Conservative measures (over 6 months) have been exhausted including rest, activity modification, pain relief, NSAIDS, splinting, exercises, as appropriate.   **AND**   1. Patients with:    1. Neurovascular compromise (Evidenced by USS or MRI and clear clinical findings)   **OR**   * 1. Where ganglion only forms part of or maybe is secondary to the diagnosis (i.e. underlying OA or instability) where the underlying problem can only be resolved by removal of the ganglion.   **OR**   * 1. Patients with persistent foot and ankle ganglia (over 6 months) pain and functional limitation (difficulty working, or doing everyday activities, wearing normal footwear) evidenced by ultrasound or photographs.   **Notes:**   1. All patients should be referred via the community Musculoskeletal (MSK) Interface Service. 2. If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form. | YES  NO  YES  NO  YES  NO  YES  NO |

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| **Supporting Information** |  | |
| **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.** | | |