Patient Name: Address: Date of Birth: NHS Number: Consultant/Service to whom referral will be made: Institution:

NHS
West Suffolk
Clinical Commissioning Group

Please send this form with the referral letter or to the consultant who you sent the referal to

T46 - Threshold policy: Pinnaplasty in children.

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Consultants: Please complete the box below and file for future compliance audit.

WSCCG will only fund these procedures when ALL the following criteria are met

	Tick
The patient is over the age of 11 but under the age of 19	☐
The patient (not the parents alone) desires surgical correction*	☐
In the professional opinion of the GP the prominence is of a severity that it presents as disfigurement	☐
There is supporting documented evidence from a health professional and the child's school that the health and wellbeing of the child is being adversely affected despite all reasonable steps being taken to address the issue (for example, low attendance rate at school and or poor educational performance).	☐
It is the opinion of the child's health professional that the adverse impact on the child's health and wellbeing is likely to be remedied through correction of the deformity, **OR** Correction of ear prominence is required to better support a hearing aid	☐ ☐
This procedure is NOT for cosmetic reasons	☐

** Referrals should not be made for children who appear indifferent or opposed to the idea of surgery. Parents requesting surgery for their child in order to prevent psychological distress should be advised that referral should wait until their child specifically requests treatment.*

Information Governance Statement

All Prior Approval Requests must be reviewed by the clinical commissioning group (CCG) as the statutory body responsible for funding decisions. This application form and other supporting information supplied may be shared with the CCG. If so, personal information will be retained only for the purposes of this Prior Approval Request and, in some cases, may be used for invoicing and payment reconciliation. The patient's medical records may be used for the purpose of clinical audit which will be completed by a clinician. Anonymised information may also be shared as part of the CCG reporting process.

Does the patient consent to the sharing of their personal information? *Y/N*

Refusal of consent will not preclude application of this referral. However, the referring body must ensure that all personal identifiable data is redacted from this application.

Consultant use only

Please complete the following and file for future compliance audit.

Referral criteria is met and
the patient will benefit from
the proposed treatment: yes / no

Signature……

Date:

Consultant name: ……
Please print

Hospital: ……

GP use only

Practice stamp/address

Referring clinician: ……..

Date: ……..

Commissioner's use only

Criteria met as per policy: yes / no

Compliance with notes: yes / no

Audit date: ……

Audited by: ……..
Please print

(GP/Cons)