

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



Lifestyle Information		
Latest BMI:	Latest BP:	Smoking Status:
Has the patient been referred for: <input type="checkbox"/> Weight Management <input type="checkbox"/> Smoking Cessation		

T36: Uterine Artery Embolisation in the Non-Operative Treatment of Fibroids

Instructions for use:

To GPs: Please refer to the above policy and complete the following form prior to referral and provide evidence to support the criteria.

To Consultants: Please complete the box below and ensure there is evidence that the criteria are met.

This policy covers the treatment procedure, uterine artery embolisation (UAE) in the non-operative treatment of fibroids. Uterine artery embolisation is not considered an appropriate treatment for women who have not completed their family as the effects of UAE on fertility and pregnancy remain uncertain.

The vast majority of patients are expected to be managed in the primary care setting. However, some patients may need referral to a specialist.

<i>In ordinary circumstances*</i> , referral should not be considered unless the patient meets all of the following criteria. Please consider all avenues for management in Primary care (including referral to locally enhanced services) prior to referral to Secondary care	Please tick if criteria met
The patient is symptomatic and conservative management (including but not limited to; gonadotropin releasing hormone analogues (GnRHAs), non-steroidal anti-inflammatory drugs (NSAIDs), hormone replacement therapy (HRT), Levonorgestrel intrauterine system (LNG-IUS), tranexamic acid, other appropriate contraceptives, Ulipristal acetate) if clinically appropriate, has been unsuccessful AND	<input type="checkbox"/>
The patient cannot or does not wish to proceed to surgery AND	<input type="checkbox"/>
The patient is aged ≥ 45 years who is expected to reach the menopause within the next 5 years AND	<input type="checkbox"/>
The patient is aware that symptoms may not be relieved or could return AND	<input type="checkbox"/>
The patient is aware of the risk to fertility and is not considering future pregnancy	<input type="checkbox"/>

*If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to NHS Suffolk's Individual funding request policy for further information.

This procedure should only be carried out by radiologists with the appropriate training and competence.

Version No	Updated by	Date updated
3.1	IESCCG Clinical Threshold Service	May 2018

Consultant use only

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

Signature.....

Consultant name:

Please print

Hospital:Date.....

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)

Information Governance Statement for West Suffolk CCG Patients only

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.

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3.1	IESCCG Clinical Threshold Sertvcie	May 2018