Lifestyle Information

<table>
<thead>
<tr>
<th>Latest BMI:</th>
<th>Latest BP:</th>
<th>Smoking Status:</th>
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Has the patient been referred for:  
- [ ] Weight Management  
- [ ] Smoking Cessation

T44: Radiofrequency Denervation in the management of persistent (chronic) back pain

Instructions for Use:

To Referring Clinicians (e.g. 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.

In ordinary circumstances*, 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

<table>
<thead>
<tr>
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<th>Please tick if criteria met</th>
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<tbody>
<tr>
<td>The patient is aged 18 years or over AND</td>
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<tr>
<td>The patient is part of a comprehensive pain management programme, and all conservative management options (including physiotherapy, guided exercise programmes and pharmacotherapy including analgesia) have been tried and failed AND</td>
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<tr>
<td>The patient has experienced severe levels of localised back pain (using a visual analogue scale, or equivalent) and significant impact of pain (using Brief Pain Inventory as per the national pain audit OR locally agreed questionnaire) lasting for more than 6 months AND</td>
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<tr>
<td>Patient’s symptoms are not consistent with identifiable pathology including disc herniation and spinal stenosis AND</td>
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<tr>
<td>Back or neck pain predominates over limb pain AND</td>
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<tr>
<td>Two diagnostic medial branch block procedures, provided under a standard protocol, produce symptom relief that is physiologically consistent with the main source of pain being structures supplied by medial branch nerve pathology</td>
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*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.
### Consultant use only

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

Signature: ____________________________

Consultant name: ____________________

Hospital: ____________________________ Date: ____________

### GP use only

Practice stamp/address

### Commissioner’s use only

Criteria met as per policy: **yes / no**

Compliance with notes: **yes / no**

Audit date: __________________________

Audited by: __________________________

Please print

Referring clinician: ____________________ Date: ____________

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

### 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.