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

NHS
West Suffolk
Clinical Commissioning Group

Lifestyle Information		
Latest BMI:	Latest BP:	Smoking Status:
Has the patient been referred for:	☐ Weight Management	☐ Smoking Cessation

T41 Surgical Treatment of Hallux Valgus and Hallux Rigidus (Bunions)

Instructions for use: Please refer to the full policy for further details and send to SCH at:
WSCCG.suffolk-podiatry@nhs.net

To GPs and Consultants: Surgical treatment of Hallux Valgus and Hallux Rigidus is considered a low priority treatment and will only be funded by IESCCG if the criteria below have been met. Please complete the following form and provide evidence of the criteria. Referral must not be made for prophylactic or cosmetic purposes. This policy does not apply to anyone under 19 years of age. Minimal access techniques are not covered by this policy

The vast majority of patients with hallux valgus (bunions) or hallux rigidus are expected to be managed in the primary care setting. However, some patients may need referral to a specialist

Exclusions to policy: Complicated hallux valgus (bunions) or hallux rigidus e.g. with impending or non-healing ulcer or peripheral limb ischaemia, are not covered by this policy. These should be managed as clinically appropriate on a case by case basis.

Patients should only be referred for treatment if they meet the following criteria[1]:	**Please tick one:**
• The patient is symptomatic with persistent pain that is significant and prevents the patient fulfilling work, educational, domestic or care activities **AND**	☐
• Where clinically appropriate a trial of at least six months' conservative treatment* has failed and not addressed the symptoms **AND**	☐
• Patients with a BMI of > 30kg/m² are encouraged to attend the commissioned weight management services **AND**	☐
• Symptoms are continuing to deteriorate **OR** • There is functional impairment** **OR** • An inability to wear suitable shoes **AND** • The patient is willing to undergo surgery*** understanding that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks (2 weeks if left side and driving automatic car)	☐ ☐ ☐ ☐

if the clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG's Individual funding request policy for further information.

Version Number	Date reviewed	Reviewed by
2.1	June 2017	Clinical Threshold Service

NHS No:

*Conservative measures include avoiding high heel shoes and wearing wide fitting leather shoes which stretch, exercises specifically designed to alleviate the effects of a bunion and keep it flexible, applying ice and elevation for painful swollen bunions, simple analgesia and non-surgical treatments such as bunion pads, splints, insoles or shields

**Functional impairment must be significant and prevent fulfilling work, educational, domestic or carer activities

***The patient should be informed that the decision to have surgery is a dynamic process and a decision not to undergo surgery does not exclude them from having surgery at a future time point. Referral must not be made for prophylactic or cosmetic purposes

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? Yes / No

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

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)

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2.1	June 2017	Clinical Threshold Service