

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

Patient Name:	\$(Title_and_surname) \${Forename}
Address:	\$(Patient_address)
Date of Birth:	\$(Date_of_birth)
NHS Number:	\$(NHS_number)
Consultant/Service to whom referral will be made:	
Institution:	

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

## T14 Hysterectomy for Heavy Menstrual Bleeding.

### 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.*

Instructions for use:

**To GP's:** Please refer to the above policy and complete the following form providing evidence to support the criteria

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

Clinicians should investigate and manage HMB as per NICE recommendations laid out in the HMB pathway, CG44 and QS47."

WSCCG will only fund hysterectomy when the following criteria are met:

**Hysterectomy for HMB will only be funded if ALL the following criteria are met\***

A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialled for <i>at least 6 months</i> (unless contraindicated** or declined by patient) and has not successfully relieved symptoms.	Y/N
A trial of <i>at least 3 months each</i> of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, intolerable or declined by the patient). These treatment options include:  <ul style="list-style-type: none"> <li>- NSAIDs e.g. mefenamic acid</li> <li>- Tranexamic acid</li> <li>- Combined oral contraceptive pill</li> <li>- Oral and injected progestogens</li> </ul>	Y/N

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Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE)** have either been ineffective or are not appropriate, contraindicated or declined by the patient	Y/N
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\* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information.

\*\*Contraindications to LNG-IUS use include suspected or confirmed untreated sexually transmitted infections (STIs), pregnancy, pelvic inflammatory disease (PID), distorted or small uterine cavity, active trophoblastic disease, genital malignancy and immunosuppression.

\*\*UAE may be appropriate for some women with HMB associated with uterine fibroids, for more information see policy T36.

**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: Y/N

Signature.....

Date:

Consultant Name:

Institution:

**GP Use Only:**

Practice Stamp/Address:

Referring Clinician \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**For Commissioners Use:**

Criteria met as per policy            Y/N

Compliance with notes                Y/N

Audit Date:

Audited by:

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