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:	

NHS
West Suffolk
Clinical Commissioning Group

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

Lifestyle Information		
Latest BMI: ${Latest_BMI}	Latest BP: ${Latest_BP}	Smoking Status:
Has the patient been referred for:	☐ Weight Management	☐ Smoking Cessation

T17 Spinal Surgery for Non Acute Lumbar Conditions

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: Please further refer to the full policy for details.

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.

WSCCG will only fund surgery for **Chronic Low Back Pain** when the following criteria have been met:

Patients with **chronic low back pain** will be considered for surgical management under the following circumstances:	
Spinal Fusion may be considered in selected patients with degenerative disc disease who are unresponsive to conservative management* after one year and are being documented as significantly interfering with quality of life (as measured by an appropriate measurement tool such as EuroQ015D.	Y/N
Patients should be non-smoking** at time of surgery as the rate of potential fusion is significantly affected by smoking.	Y/N

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Patients should have a Body Mass Index of <30 BMI:…….	Y/N

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to West Suffolk CCG's Individual Funding Request (IFR) policy for further information.

*Conservative management should include a combined physical and psychological treatment programme. Surgery will only be considered when there is documented evidence that the patient has engaged and has participated in the full programme.

**Patients who smoke should have stopped smoking 8-12 weeks before surgery to reduce the risk of surgery and the risk of post surgery complications and this should be determined by testing at an appropriate time during the pathway, for example at the pre-assessment clinic. The average waiting time for surgery is 12 weeks. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

West Suffolk CCG will only fund surgery for Sciatica or Spinal Stenosis when the following criteria have been met:

Patients with **sciatica or spinal stenosis** will be considered for surgical management under the following circumstances:	
A failure to improve over a 3 month period despite all the following conservative management where clinically appropriate: • Physiotherapy • Adequate analgesia including anti-neuropathic medication.	Y/N
Exclusion Criteria Any patient presenting with abnormal or progressive neurology are excluded from this policy.	

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to West Suffolk CCG's Individual Funding Request (IFR) policy for further information.

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:

Version No	Updated by	Date updated
2.1	V Stearn	Feb 2017