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

T20 Upper Eyelid Functional Blepharoplasty

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/ optometrists: Please refer for assessment of Upper Eyelid Functional Blepharoplasty if deemed clinically appropriate.
To Consultants: Please complete the boxes below and ensure there is evidence to support the criteria

WSCCG will only fund Upper eyelid functional Blepharoplasty when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets* ***one or more*** *of the following criteria.*

To repair defects predisposing to corneal or conjunctival irritation such as entropion or pseudotrichiasis?	Y/N
To treat periorbital sequelae of thyroid disease/nerve palsy/blepharochalasis/floppy eyelid syndrome/chronic inflammatory skin conditions?	Y/N
To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue?	Y/N
Following skin grafting for eyelid reconstruction?	Y/N
At The same time as ptosis correction for the upper eyelid if the surplus skin is felt to be excess on lifting the ptotic eyelid	Y/N

Version No	Updated by	Date updated
2.1	V Stearn	Feb 2017

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to CCG's Individual funding request policy for further information.*

If the above criteria are not met, does the patient meet ALL of the following exceptions:–

Documentation that the patient complains of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin	Y/N
There redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead	Y/N
Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 40° or less superiorly.	Y/N

Consultant Use Only:

Please complete the following and file for future compliance audit.

Referral criteria met and the patient will benefit from the proposed treatment: Y/N

Signature………………………………….

Estimated date of treatment: ___/___/___

Consultant Name:

Institution:

GP / Optometrists 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