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

**Lifestyle Information**

<table>
<thead>
<tr>
<th>Latest BMI:</th>
<th>Latest BP:</th>
<th>Smoking Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>${Latest_BMI}</td>
<td>${Latest_BP}</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has the patient been referred for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Weight Management</td>
</tr>
</tbody>
</table>

T26 Female Surgical Interval Tubal Sterilisation

**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?**

<table>
<thead>
<tr>
<th>Y/N</th>
</tr>
</thead>
</table>

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 Referring Clinicians (e.g. GP’s):** Please refer to the above policy, complete the 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 Female Surgical Interval Tubal Sterilisation when the following criteria are met:

*In ordinary circumstances*, referral should only be considered if the patient meets **ALL** of points 1-4 **AND** Either criteria 5 or 6.

<table>
<thead>
<tr>
<th>1. Is the woman certain her family is complete or that she never wants children. She must be aware that the procedure is considered permanent and that reversal is not routinely funded on the NHS.</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The woman has received counselling about her options including consideration of all other forms of long-acting contraceptives. If she has a partner, has he considered vasectomy?</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. The woman have sound mental capacity?</td>
<td>Y/N</td>
</tr>
<tr>
<td>4. Is the patient’s body mass index (BMI) &lt; 35?</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**BMI:** .........................
5. Has the LNG-IUS, POI or DMPA been used for a flexible 12 month trial***?
   - Levonorgestrel intrauterine system (LNG-IUS)  Y/N
   - Progesterone only implant (POI)  Y/N
   - Depot Provera (DMPA)  Y/N

OR

6. The woman has a medical condition making pregnancy dangerous.  Y/N

*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.

** Additional care must be taken when counseling individuals under the age of 30 years or individuals without children who request sterilization.

*** Flexible 12 month trial: If the patient wishes to accept a trial of a long acting reversible contraceptive, she will be offered a flexible 12 month period unless extending the trial to 12 months would not be of benefit to the patient (i.e. the side effects are affecting the patient’s quality of life).

For further information please see the IESCCH T26 policy

The following indication for female sterilisation is exempt from the criteria:

The woman has a medical condition making pregnancy dangerous.  Y/N

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

<table>
<thead>
<tr>
<th>Where sterilisation is to take place at the time of another procedure such as caesarean section (counseling and consent should have been given at least one week prior to the procedure).</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there is a contraindication to the use of a LARC?</td>
<td>Y/N</td>
</tr>
<tr>
<td>Is there an absolute contraindication to pregnancy?</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**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: