

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:	

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: <input type="checkbox"/> Weight Management <input type="checkbox"/> Smoking Cessation		

### T31 Surgery for Female Urinary Incontinence and Symptomatic Pelvic Organ Prolapse

#### 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/Community Continence Team/ IHT Gynae Physio Team: 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 surgery for Symptomatic pelvic organ prolapse 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.*

Presence of BOTH pelvic organ prolapse AND urinary or faecal incontinence.	Y/N
Trial of a pessary has either failed to satisfactorily relieve symptoms, OR is unacceptable to patient with a symptomatic pelvic organ prolapse.	Y/N

WSCCG will only fund surgery for female urinary incontinence 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.*

Stress urinary incontinence (SUI): Patient has undergone a minimum of 3 months supervised pelvic floor training without satisfactory resolution of symptoms.	Y/N
Urgency urinary incontinence (UI): Patient has undergone a minimum of 6 weeks bladder retraining plus 4 weeks treatment with an anticholinergic drug if appropriate, without satisfactory resolution of symptoms.	Y/N
AND there is documented evidence that the patient has received lifestyle advice where applicable regarding reduced caffeine intake, appropriate fluid intake, smoking cessation and weight loss if BMI>30.	Y/N

*\* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to I&ES CCG and WS CCG Individual funding request policy for further information.*

*N.B. Patients with associated symptoms suspicious of malignancy (for example visible haematuria, microscopic haematuria in the over 50s, mass arising from urinary tract) should be urgently referred to secondary care.*

**Consultant Use:**

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: