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 referal to

T33 Labiaplasty

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Consultants: Please complete the box below and file for future compliance audit.

I&ES CCG and WSCCGs' will only fund Labiaplasty 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.*	Y/N (delete as appropriate)
The presence of another medical condition (such as cancer or congenital malformation) has caused labial hypertrophy and there is clinical indication for labiaplasty.	Y/N
Repair to the labia is required following trauma, including traumatic birth injury.	Y/N

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

. ***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.

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……..

Date:

Consultant Name:

Institution:

GP Use Only:

Practice Stamp/Address:

Referring Clinician _____

Date: ___/___/___

For Commissioners Use:

Criteria met as per policy Y/N
Audit date: ___/___/___

Compliance with notes Y/N
Audit date: ___/___/___

(GP/Cons)