| | |
|---|---|
| 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**

# T48 Hip Arthroscopy

## *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 Referring Clinicians (e.g. GP's)**: Please refer to the full policy and complete the box below prior to referral and provide evidence to support the criteria.
**To Consultants:** Please refer to the full policy, complete the box below and ensure there is evidence that the criteria are met.

The CCG will only fund Hip Arthroscopy when the following criteria have been met:

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

## Femoro-acetabular impingement (FAI)

| | |
|---|---|
| Evidence of FAI as demonstrated by clinical assessment/radiological investigation **AND** | Y/N |
| Severe symptoms typical of FAI (hip pain that is worsened by flexion activities e.g., squatting or prolonged sitting) that significantly limits activities, with duration of at least six months where diagnosis of FAI has been made as above **AND** | Y/N |
| Failure to respond to all available conservative treatment options including activity modification (e.g., restriction of athletic pursuits and avoidance of symptomatic motion), pharmacological intervention and physiotherapy **AND** | Y/N |
| Other treatment options if clinically relevant and appropriate such as hip replacement or resurfacing have been considered **AND** | Y/N |
| Patient is aged between 18 and 50 years. However the consultant can offer the procedure outside of this age range if in their expert opinion this will be the best option for the patient | Y/N |

## Labral tears

| | |
|---|---|
| For repair/excision of labral tears that have been identified by radiological investigation **AND** | Y/N |
| There is no evidence of osteoarthritis or FAI in the joint | Y/N |

## Loose bodies

| | |
|---|---|
| Therapeutic arthroscopy for loose body in the joint that has been identified by radiological investigation( Diagnostic arthroscopy is not funded for suspected loose bodies) | Y/N |

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

## Please Indicate:

| | |
|---|---|
| LEFT | RIGHT |

**Stipulation**

The patient **must** be added to the national non hip arthroplasty register (NAHR – National Hip Society) if criteria is met to be eligible for funding.

**Consultant use only**

Please complete the following and file for future compliance audit.

Referral criteria is met and Clinical details documented in patient notes: yes / no

Signature…….

Date …….

Consultant name: …….
Please print

Provider: ……

**GP use only**

Practice stamp/address

Referring clinician: ……..

Date: ……..

**Commissioner's use only**

Criteria met as per policy: yes / no

Compliance with notes: yes / no

Audit date: ……

Audited by: ……..
Please print

(GP/Cons)