T54 Nail Surgery for Ingrown Toenails

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 WS CCG will only fund Nail surgery for ingrown toenails when one the following criteria are met:

| Patient is in clinical need of surgical removal of ingoing toe nail has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. | Y/N |
| Patient has infection and/or recurrent inflammation due to ingrown toenail AND has high medical risk*. | Y/N |

*Medical risk is determined by the referring clinician - including, but not limited to, vascular disease, neurological disease or diabetes which are categorised as having high medical need due to the risk of neuropathic complications.

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.

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

Audit date: ___/___/___

Compliance with notes  Y/N

Audit date: ___/___/___