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:** [ ] Weight Management [ ] Smoking Cessation

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**T7b Grommets in Adults**

**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:

Please further refer to the policy for full details.

**To GP’s and Consultants:** Please refer to the above policy and complete the following form providing evidence to support the criteria.

**To Consultants:** Please complete the box below and ensure there is evidence that the criteria is met.

This policy **applies to adults only**. Please see policy T7a for the policy and checklist applying to children (under 18).

**N.B.:** In cases of otitis media with effusion in adults, grommets are not routinely funded as unlike in children where the outcome of OME is generally good, this is not clear in adults.

WSCCG will only fund grommet insertion in adults (aged 18 and over) 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.

<table>
<thead>
<tr>
<th>Insertion of grommets as part of a more extensive surgical procedure</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a treatment for Ménière’s disease</td>
<td>Y/N</td>
</tr>
<tr>
<td>Severe retraction of the tympanic membrane and in the expert view of the consultant that this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

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**Version No** | **Updated by** | **Date updated**
---|---|---
2.1 | V Stearn | Feb 2017
<table>
<thead>
<tr>
<th>Condition</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eustachian tube dysfunction that prevents the commencement or completion of hyperbaric oxygen treatment</td>
<td></td>
</tr>
<tr>
<td>Acute or chronic otitis media with risk of complications of facial palsy or intracranial infection e.g. meningitis</td>
<td></td>
</tr>
<tr>
<td>In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinusasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician</td>
<td></td>
</tr>
<tr>
<td>There is severe pain due to air pressure changes when flying or in hyperbaric treatment. The severity and frequency of flying should be discussed with the patient and balanced against the possible complications associated with grommets.</td>
<td></td>
</tr>
</tbody>
</table>

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

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**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: