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

T9a Carpal Tunnel Syndrome Surgery.

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.

I&ES CCG and WS CCGs' will only fund Carpal Tunnel Surgery 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.*

Criteria	
Severe symptoms at presentation – including documented evidence of sensory blunting, muscle wasting, weakness on thenar abduction or symptoms significantly interfere with daily activities	Y/N
If there is no improvement in mild-moderate symptoms after 6 months of conservative management** **nocturnal splinting and two local corticosteroid injections	Y/N

Date of First corticosteroid injection	
Date of Second corticosteroid injection	
Date for commencement of nocturnal splinting	

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

Please Indicate:

LEFT	*RIGHT*	*BILATERAL*

Consultant use only	**GP use only**	**Commissioner's 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: ………………………………	Practice stamp/address Referring clinician: …………………….. Date: ……………………………………..	Criteria met as per policy: yes / no Compliance with notes: yes / no Audit date: ………………………………… Audited by: ……………………………….. Please print (GP/Cons)