**BUNION (AND OTHER PAINFUL TOE CONDITION)**

**Prior Approval Treatment: Application Form**

Please refer to the Generic EBI application form for applications that DO NOT MEET Prior Approval criteria

**Please complete electronically – Handwritten applications can no longer be processed**

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| **Date of Application** | |  | | | | | | | | | | |
| **PATIENT INFORMATION** | | **PRIVATE & CONFIDENTIAL** | | | | **SM** |  | |  |  |  |  |
| **Does this case need to be reviewed urgently due to clinical need?** *If yes, please explain.* | | **YES**  **NO** | If yes, please state any clinical reasons that may make this application clinically urgent: | | | | | | | | | |
| **Name** | |  | | | | **Gender** | |  | | | | |
| **Address** | |  | | | | | | | | | | |
| **Date of Birth** | |  | | **NHS Number** | |  | | | | | | |
| **I understand that it is a legal requirement for fully informed consent to be obtained from the patient (or their legitimate representative) prior to disclosure of their personal details** for the purpose of a Panel/EBI team to decide whether this application will be accepted, and treatment funded. *[The information shall be legitimately shared under Article 6(1) (e) Public Task and Article 9(2) (h) Provision of Health Treatment of the GDPR].*  **By submitting this application form I, the referring clinician, confirm the patient or patient representative has been informed of the details that will be shared for the aforementioned purpose and consent has been given.** | | | | | | | | | | | | |
| **Patient’s BMI** | | |  | | --- | |  | | **Date Recorded by Clinician** | | | |  | | --- | |  | | | | | | | |
| **Patient’s Smoking Status** | |  | | | | | | | | | | |
| **Applications received without a Clinician / GP name CANNOT BE PROCESSED** | | | | | | | | | | | | |
| **Details of the GP OR Clinician completing the application form** | | | | | | | | | | | | |
| **Name of GP / Clinician** | |  | | | | | | | | | | |
| **Role / Job Title** | |  | | | | | | | | | | |
| **GP Practice or Hospital Address** | |  | | | | | | | | | | |
| **Telephone** | |  | **Email** | |  | | | | | | | |
| ***Please note.* If the clinician is completing the application form on behalf of the patient, GP details are also required. Please state GP details below.** | | | | | | | | | | | | |
| **GP Name** |  | | **GP Practice and Address** | |  | | | | | | | |

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| **CLINICAL EVIDENCE STATEMENT**  This application CANNOT BE PROCESSED unless clear clinical evidence, to support criteria being met, is provided with the application form. The clinical evidence obtained by a clinician will usually be recorded in notes or letters and copies of all relevant evidence should be supplied.​    **Clinical evidence required to demonstrate criteria have been met:**   * **Clear and full relevant history** e.g. Symptoms, duration and time course, fluctuations, nature, and severity, exacerbating and relieving factors, and clinical impact upon activities of essential daily living * **Examination findings and investigation results** * **Copies of all relevant Clinical Notes** * **GP summary and/ or patient management plan**   **Patient letter to support clinical evidence:**  A letter from the patient, written to support clinical evidence provided, may be considered with an application e.g., clinical impact upon activities of essential daily living.  ***Please Note.*** According to NHSE guidance, Social, Emotional and Environmental factors *i.e., income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application.  **Do you comply with this statement? *Please* *mark* *the box with an* X** |

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| **CRITERIA** | | | | | |
| 1. Surgical correction of hallux valgus using minimal access techniques is **NOT** **routinely commissioned** | | | | | |
| 1. **Left foot** | **YES** | **Right foot** | **YES** | **Number and type of Toes** | |
| 1. **Surgical Foot Treatments (for example: Hallux Rigidus, Hammer, Mallet, or Claw Toe) will be authorised where the following criteria are met:** | | | | | |
| 1. The referral is NOT being made for cosmetic purposes **AND the patient** | | | | | **YES** |
| 1. Has untreated hallux valgus deformity and has diabetes (or another cause of peripheral neuropathy) which puts them at risk of deep infection/amputation **OR** | | | | | **YES** |
| 1. Is suffering from severe deformity of overriding toes **OR** | | | | | **YES** |
| 1. Has persistent moderate/severe symptoms (covered by the other conditions in the background information section 3) despite 6 months of conservative management as detailed in point 4 below | | | | | **YES** |
| 1. **Patients have persistent moderate/severe symptoms despite 6 months of conservative management which must include ALL the following:** | | | | |  |
| 1. Modification of footwear: avoidance of high-heeled shoes, wearing wide cut or especially altered shoes with increased medial pocket to minimise deforming forces; **AND** | | | | | **YES** |
| 1. Externally fitted devices to improve alignment and reduce irritation, e.g., orthoses and bunion pads; **AND** | | | | | **YES** |
| 1. Stretching exercises to improve/maintain joint flexibility; **AND** | | | | | **YES** |
| 1. Ice and elevation for pain and swelling; **AND** | | | | | **YES** |
| 1. Optimum analgesia | | | | | **YES** |
| 1. The patient is fit for surgery and understands if approved for surgery they will be unable to drive for 6 weeks *(or 2 weeks after surgery on the left foot if they drive an automatic car). Also, where applicable, they will be off work for a minimum of two weeks* | | | | | **YES** |
| 1. **Additional supporting information can be typed here or attached:** | | | | |  |
| **PLEASE NOTE:** Where an original funding authorisation is for a toe and the secondary care clinician determines when seeing the patient that further surgery is clinically appropriate to other toe(s) on the same foot, the provider may undertake the other procedure(s) without seeking further funding authorisation where clinical circumstances fall under all the following conditions.   * The NHS Somerset Bunion & Other Painful Toe Treatments Policy criteria is fulfilled for the other toe(s) * The treatment would be undertaken within the same episode of care   The medical notes must clearly document how the policy treatment criteria have been met for the surgery of the additional toe(s) | | | | | |

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| **Evidence provided to support the above criteria have been met,** please indicate the relevant documents includedin this application:  **Is a Patient Management Plan included with this application?**  ***Are copies of relevant clinical notes included with this application?***  **Is a Referral Letter included with this application?**  ***Are all relevant Clinician(s) Letters included with this application?***  **Is a Patient Letter to support clinical evidence, included with this application?**  **By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete.** *Please mark the boxes below.*  Have you referred to the relevant NHS Somerset ICB EBI policy prior to completing this PA application form?    Have you had a conversation with the patient about the most significant benefits and risks of the intervention?  Have you attached all the clinical correspondence to evidence that criteria have been met?  Have you discussed with the patient whether any additional communication requirements are needed? e.g., different language, format. | **YES**  **NO**  **YES  NO**  **YES  NO**  **YES  NO**  **YES  NO** |

**Email the completed Prior Approval Application form and clear clinical evidence to support the application to:** [**ebisomerset@nhs.net**](mailto:ebisomerset@nhs.net)

***Please note.* Printed / scanned application forms sent by email cannot be processed**