***GENERIC* EVIDENCE BASED INTERVENTIONS (EBI) APPLICATION**

For interventions not commissioned by Somerset ICB or where published criterion is not fulfilled

**Please complete electronically – Hand written 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 without clear clinical evidence to demonstrate clinical exceptionality of the patient and their condition.   1. **Definition of Clinical Exceptionality**   *‘Where a patient’s individual clinical circumstances are clearly different from other patients with a similar condition or diagnosis.’*  For further information on clinical exceptionality, please refer to the NHS Somerset ICB website and input into the ‘Search this website’ box clinical exceptionality. Click on the link to access the full NHS description of clinical exceptionality.  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.   1. **Clinical evidence required to demonstrate clinical exceptionality:**  * **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** * **GP summary and/or a description of the clinical management plan** * **Secondary Care correspondence relevant to the condition and the intervention requested**   ***Please note.*** Copies of all relevant clinical evidence should be supplied.​   1. **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.***  Refer to point 1 above with reference to social, emotional and environmental factors.  **I have read and comply with this statement, *please* *mark* *the box with an* X** |

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| **Please answer the MANDATORY questions below;** | | | | | | | | | | | |
| **Q1** | What intervention is being requested? | | | | |  | | | | | |
| **Q2** | What is the clinical need for the intervention? | | | | |  | | | | | |
| **Q3** | What is the Clinical Exceptionality of this patient | | | | | This is the most important MANDATORY part of the EBI generic funding application. Please state how the patient is deemed to be clinically exceptional. | | | | | |
| **Q4** | Please provide brief details of the patient’s condition; symptoms, duration and time course, fluctuations, nature and severity | | | | | | | | | | |
| **Date** | | | | |  | | | | | | |
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| **Q5** | | Please provide details of the relevant clinical history e.g. trialed interventions/treatment | | | | | | | | | |
| **Date** | | | | **Intervention** | | | | **Reason for stopping/Response achieved** | | | |
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| **Q6** | | Please detail the duration for the  treatment  requested if applicable | | | | | e.g. length of time the treatment / medication is required | | | | |
| **Q7** | | Please state all  associated costs if known: i.e. Device/s  Clinical / theatre time  Pharmaceuticals  Other | | | | |  | | | | |
| **Q8** | | 1. How many patients have presented to you with this condition if known. Please provide the year and number of patients each year below | | | | | | | | | Not known |
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|  | | 1. Please indicate the severity of your patient’s condition against a previous patient/s who presented with this condition if known. | | | | | | | | | Not known |
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| **Q9** | | | Please provide evidence of efficacy of the intervention/treatment requested | | | | | | | | |
| *Please attach full journal articles or* *NICE guidance*, including additional sheets if necessary (e.g. NICE/Scottish Medicines Consortium/ASW Cancer Forum/All Wales Medicines Strategy/London New Drugs/ journals/publications) | | | | | | | | | | | |

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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?**  **Is a GP Summary included with this application?**    **Is a Referral Letter included with this application?**  **Is a Clinician(s) Letter 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 SICB 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 Generic 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**