**PERCUTANEOUS TIBIAL NERVE STIMULATION (PTNS)** **URINARY INCONTINENCE**

**SECONDARY CARE 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 – 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 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 * **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. NHS England is responsible for commissioning highly specialist adult urology and gynaecology services <https://www.england.nhs.uk/wp-content/uploads/2019/11/E10-Sacral-nervestimulation-for-overactive-bladder.pdf> | |
| Funding Approval for PTNS treatment will only be authorised for patients meeting criteria set out below; | |
| 1. Botulinum toxin injection and sacral nerve stimulation may be used in patients for whom conservative treatments have been unsuccessful;  * First-line treatments for an over active bladder include;  1. Bladder training 2. Pelvic floor muscle training 3. Anticholinergic drugs | **YES**  **YES**  **YES** |
| 1. Patients fulfill **NICE IPG362** | **YES** |
| 1. The following pathway has been followed & the clear clinical evidence has been provided with this PA application; |  |
| * 1. There has been a multidisciplinary team (MDT) review (please provide a copy of the clinical minutes, showing the date and attendance) **AND** | **YES** |
| * 1. Non-surgical management including overactive bladder medicine treatment has not worked adequately **AND** | **YES** |
| * 1. The patient does not want;      + botulinum toxin A **OR**      + percutaneous sacral nerve stimulation [new 2013] | **YES**  **YES** |
| **Additional supporting information can be typed here or attached:** | |

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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**