**BREAST ASYMMETRY SURGERY**

**Prior Approval Treatment**

**Application Form**

**Please complete electronically – Handwritten applications CANNOT be processed**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | | | | | | | | | | |
| **The Clinician** completing the application form please put your details below | | | | | | | | | | | | |
| **Name of GP / Clinician** | |  | | | | | | | | | | |
| **Role / Job Title** | |  | | | | | | | | | | |
| **GP Practice or Hospital Address** | |  | | | | | | | | | | |
| **Telephone** | |  | **Email** | |  | | | | | | | |
| ***Please note.* If the clinician completing this application form is not the patients GP please input the patients GP details below** | | | | | | | | | | | | |
| **GP Name** |  | | **GP Practice and Address** | |  | | | | | | | |

|  |
| --- |
| **CLINICAL EVIDENCE STATEMENT**  ***Please note.*** This application CANNOT BE PROCESSED without relevant clinical evidence to demonstrate that the Policy Criteria for the requested treatment has been met by the patient.    Copies of relevant clinical evidence should be provided with the application as follows:   * **Relevant clinical history relating to the intervention requested** e.g. symptoms, duration and time course, fluctuations, nature and severity, exacerbating and relieving factors, and clinical impact upon activities of essential daily living. This may include all relevant consultation notes /letters. * **Relevant summary of medical history** * **All relevant Diagnostic Reports and Investigation Results** * **All relevant Secondary Care Reports and correspondence relating to the intervention requested** |

|  |  |  |
| --- | --- | --- |
| **CRITERIA**  **To be completed by the clinician requesting the treatment** | | |
| 1. Patients Age in years (18 years of age or above) | Input age |  |
| 1. Patients BMI is within the BMI range of 19 to 27 and has been sustained for a minimum of 6 months | YES  NO | |
| 1. Patients have not smoked/used nicotine replacement therapy over the preceding 3 months | YES  NO | |
| 1. Patient has a disparity of 2 cup sizes or greater in the lower range (size C or below) based on the smaller breast size - a difference of B - D would count as 2 cup sizes **OR** | Input Cup size difference |  |
| 1. Patient has a disparity of 3 or more cup sizes in the upper range (size D upwards), based on the smaller breast size - a difference of DD - F would count as 3 cup sizes (DD, E, EE, F) | Input Cup size difference |  |
| 1. The patient acknowledges they understand they will be referred to the Somerset ICB Breast Care Nurse Service for an assessment to confirm that the specified criterion is fulfilled | YES | |

|  |  |
| --- | --- |
| **Clinical Evidence provided to support the application.** *Please, indicate the documents included**in this application:*  **Relevant clinical history relating to the requested intervention**  **is included with this application**    **A Referral Letter is included with this application**  **Relevant diagnostic reports and/or investigation results are included with this application**  **Clinician Letter/s are included with this application**  **A Patient Letter to support relevant clinical evidence is included with this application**  **By submitting this form, you confirm that the information provided is, to the best of your knowledge, true and complete.** | **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:** [**somicb.ebisomerset@nhs.net**](mailto:somicb.ebisomerset@nhs.net)