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

**Prior Approval Treatment**

**Application Form**

**Please complete electronically – Handwritten applications CANNOT 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** | | | | | | | | | | | | |
| **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** | |  | | | | | | | |

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| **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** |

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| **CRITERIA (for toe and forefoot conditions)** | | | | | |
| 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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| **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)