**LAPAROSCOPIC VENTRAL RECTOPEXY & STAPLED**

**TRANSANAL RESECTION OF THE RECTUM (STARR)**

**SECONDARY CARE 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** |
| **1.** Surgical treatment will only be provided by the NHS for patients meeting criteria set out below: |  |
| **2**. Each patient to be considered by a Multidisciplinary pelvic floor team, consisting of a  Gynaecological Surgeon, a Colorectal Surgeon and Pelvic Floor Physiologists (will  not be quorate unless a representative from each of these groups is present)  Please provide a copy of the MDT minutes showing the date, the attendees **AND** the MDT minutes confirm the following; | **YES** **[ ]**  |
|  a. MDT recommend this treatment for this patient over all alternatives | **YES [ ]**  |
|  b. The potential benefit outweighs any potential harm | **YES** **[ ]**  |
|  c. The MDT is satisfied that the necessary capacity and expertise available to handle  this intervention is in place in the proposed delivery setting **AND** | **YES** **[ ]**  |
| **4**. Conservative Management has been tried and has failed; This includes a selection of  the following appropriate for the individual:* Dietary advice; pelvic floor exercises
* osmotic and stimulant laxatives
* bulking agents and antispasmodics
* glycerine and bisacodyl suppositories and biofeedback

**AND** | **YES [ ]** **YES [ ]** **YES [ ]** **YES [ ]**  |
| **5**. The patient has unresolved faecal incontinence or obstructed defecation syndrome **AND** | **YES** **[ ]**  |
| **6**. The risks, benefits, and side effects of the procedure have been discussed with the  patient, and the patient wishes to be considered for this treatment | **YES** **[ ]**  |
| **Additional supporting information can be typed here or attached:** |  |

|  |  |
| --- | --- |
| **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**