**BLEPHAROPLASTY/PTOSIS**

**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** | |
| 1. **Prior Approval is required for Dermatochalasis/Ptosis - UPPER Lid only**   1. Significant drooping of the tissue above the eyelids (dermatochalasis) which cause   persistent impairment of visual fields in the relaxed, non-compensated state: | **YES** |
| * where there is evidence the eyelids impinge on visual fields reducing field to less than 120° horizontally and 40° vertically **OR** | **YES** |
| * where there is evidence that eyelids impinge on visual fields reducing field to less than 160° horizontally where the patient is a professional Group 2 PCV and LGV driver Group 2 PCV and LGV drivers require 160° horizontally and funding will be approved for these | **YES** |
| 2. Neck problems caused by abnormal head posture **OR** | **YES** |
| 3. Recurrent infection that is due to drooping eyelid **OR** | **YES** |
| 4. Significant impairment of the eyelid function **AND** | **YES** |
| 5. Blepharoplasty/Ptosis surgery will significantly improve the vision of the patient **AND** | **YES** |
| 6. Photographic supporting evidence has been attached **AND / OR** | **YES** |
| 7. A visual field test result is available and has been attached | **YES** |
| **Additional supporting Information can be typed here or attached:** |  |

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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)