**DUPUYTREN’S CONTRACTURE SURGERY**

**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**  |

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|       |

  | **Date Recorded by Clinician** |

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|       |

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| **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. The ICB does **NOT** commission Radiation Therapy or Collagenase Clostridium Histolyticum (CCH) for Dupuytren’s contracture
 |
| 1. Left

digit | YES [ ]  | Right digit | YES [ ]  | Number and types of digits        |
| 1. **The patient has a 30 degree or greater fixed flexion deformity (contracture) at either the:**
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| 1. Metacarpophalangeal joint **OR**
 | **YES [ ]**  |
| 1. Proximal interphalangeal joint **OR**
 | **YES [ ]**  |
| 1. Severe thumb contractures which interfere with function
 | **YES [ ]**  |
| **Additional supporting information can be typed here or attached:**      |
| **PLEASE NOTE:** Where an original funding authorisation is for a finger and the secondary care clinician determines when seeing the patient that further surgery is clinically appropriate to other digits(s) on the same hand, 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 Dupuytren’s Contracture Policy criteria is fulfilled for the other digit(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 digits(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**