**GENERIC EVIDENCE BASED INTERVENTIONS (EBI)**

**Application Form**

Application for an Intervention Not Normally Funded (INNF) by the NHS on grounds of ‘Clinical Exceptionality’

**To 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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| **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 Clinical Exceptionality of the patient.1. **Definition of Clinical Exceptionality**

‘A patient, who has a medical condition of which their clinical circumstances are exceptional when compared to a cohort of patients with the same condition, can be considered for referral on grounds of clinical exceptionality.’***Please note.****To eliminate discrimination for patients, social, environmental, workplace, and non-clinical personal factors cannot be taken into consideration.*1. **Clinical evidence required to demonstrate clinical exceptionality**

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 and 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**
1. **Patient letter to support clinical evidence:**

A letter from the Patient to support the RELEVANT CLINICAL EVIDENCE provided in terms of impact on daily living i.e. mobility, functionality, impact on other medical conditions etc. can be considered with an application.***Please note.*** *social, environmental, workplace, and non-clinical personal factors cannot be taken into consideration.*  |

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| **Clinical evidence to support a Clinical Need for treatment.** *Please answer the questions below:* |
| **Q1** | What intervention is being requested?  |       |
| **Q2** | What is the clinical need for the intervention? |       |
| **Q3** | What is the Clinical Exceptionality of this patient  | Please state how the patient is deemed to be clinically exceptional (this is the most important and MANDATORY part of the EBI generic funding application).      |
| **Q4** | Please provide brief details of the patient’s condition; symptoms, duration and time course, fluctuations, nature and severity |
| **Date** |  |
|       |       |
|       |       |
| **Q5**  | Please provide details of the relevant clinical history e.g. trialed interventions/treatment |
| **Date** | **Intervention** | **Reason for stopping/Response achieved**  |
|       |       |       |
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| **Q6** | Please detail the duration for the treatmentrequested if applicable  | e.g. length of time the treatment / medication is required      |
| **Q7** | Please state all associated costs if known i.e. Device/s Clinical / theatre timePharmaceuticalsOther |       |
| **Q8** | 1. How many patients have presented to you with this condition if known. Please provide the year and number of patients each year below
 | Not known [ ]  |
|  |       |       |       |
|  |       |       |       |
|  | 1. Please indicate the severity of your patient’s condition against a previous patient/s who presented with this condition if known.
 | Not known [ ]  |
|  |       |
| **Q9**  | Please provide evidence of efficacy of the intervention/treatment requested |
| *Please attach full journal articles or* *NICE guidance*, including additional sheets if necessary (e.g. NICE/Scottish Medicines Consortium/ASW Cancer Forum/All Wales Medicines Strategy/London New Drugs/ journals/publications)       |

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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 (including notes)****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 Generic Application form and clear clinical evidence to support the application to:** **somicb.ebisomerset@nhs.net**