PRIOR APPROVAL REQUEST

Female Sterilisation

Hertfordshire and west Essex Evidence Based Intervention policies can be viewed at <https://www.hweclinicalguidance.nhs.uk/clinical-policies>

Please complete and return this form along with clinic letter/supporting evidence to:

For west Essex patients priorapproval.hweicb@nhs.net Tel: 01992 566150 For Hertfordshire patients priorapproval.hweicb@nhs.net Tel: 01707 685354

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| **Patient consent** | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB. | Please tick |

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| **Date form completed** |  |
| **Urgency** | Routine (5 working days turnaround time)Urgent (2 working days turnaround time)**Note: An urgent request is one in which a delay may put the patient’s life at risk.****Turnaround times commence the working day after receipt of the funding application** |
| **Patient details** | Name: Date of birth: - - / - - / - - - -Address:Telephone number: NHS No:Hospital number:GP Name: Practice: |
| **Applying Clinician’s details** | Consultant Name: Hospital/Organisation: Contact details:(Including email) |
| **Declaration** | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. |

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| **1. Criteria** | 1. It is evidenced that the patient is unable to tolerate all hormonal forms of contraception.
2. The patient has been fully informed of associated health risks.
3. Clinic letter provided
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| **Non-invasive management** | **Treatment** | **Yes / No** | **Dates/Duration/Comments (evidence how the patient is unable to tolerate)** |
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| **Details must be provided** | Combined oral contraceptive pill (the pill) |
|  | Progesterone-only pill (mini- pill) |  |  |
|  | Contraceptive implant |  |  |
|  | IUS (intrauterine system or hormonal coil |  |  |
|  | Contraceptive injection |  |  |
|  | Vaginal ring |  |  |
|  | Contraceptive patch |  |  |

For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request Form can be submitted to the IFR team.

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| **Shared decision making** | Patients should be supported with their decisions. Resources that can sup- port implementation of shared decision making can be found on the NHS England website:[https://www.england.nhs.uk/shared-decision-making/guidance-and-re-](https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/) [sources/](https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/) |

HWE ICB Fitness for Elective Surgery policy criteria

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| --- | --- |
| **Smoking status** | Never smoked Current smoker Ex-smoker – date last smoked: - - / - - / - -For patients who currently smoke or have stopped smoking less than 8 weeks ago, please tick to show that you have made your patient aware that they will need to have stopped smoking or switched to e-cigarettes for at least 8 weeks prior to surgery |
| **Measurements** | Height: ……….cm Weight: …………kg BMI kg/m²**BMI >40 –** Patients are expected to reduce their weight by 15% or BMI <40 (whichever is greater).**BMI 30 40 -** Patients are expected to lose 10% of their weight or reduce BMI to <30.If the patient has already achieved their target weight loss in the last 9 months, please give details of previous recorded measurements and the date recorded by clinician or, attach referral coversheet from GP or community provider.Previous Weight: ………..kg Previous BMI kg/m²Date measured - - / - - / - - - - % weight reduction = ………….For surgery other than hip, knee or spinal, where the patient’s BMI is 30 to 40 and metabolic syndrome has been actively excluded in the last 18 months, please attach copy of evidence from GP or Community referral form.At 9 months, if the patient has not met their target weight and/or stopped smoking, they should be reassessed for their need for- and fitness for- surgery.See the Fitness for Elective Surgery policy at <https://www.hweclinicalguidance.nhs.uk/clinical-policies/fitness-for-surgery/> |