Trust/GP address

Date

IFR team

South, Central & West CSU

Omega House

112 Southampton Road

Eastleigh SO50 5PB

[Southcsu.ifrs@nhs.net](mailto:Southcsu.ifrs@nhs.net)

Dear team

Prior Approval– Eye Lid Surgery or Blepharoplasty for Ptosis & Dermatochalasis

West Hampshire and North Hampshire CCG patients

(Please indicate the intervention you are requesting)

|  |  |
| --- | --- |
| Patient Name/ DoB |  |
| NHS Number |  |
| Referring GP/ practice |  |
| Consultant/ Providing Trust |  |
| Date of clinic |  |

**Dermatochalasis** and **Ptosis of the eyelid**

Ptosis is a **sign** rather than a diagnosis and the cause must be adequately investigated and managed. Dermatochalasis is a **diagnosis** whereby there is excess skin which may eventually drop and impair vision. Abnormal head posture and headache are no longer considered criteria for intervention.

|  |  |
| --- | --- |
| Patient has objective demonstration of visual field restriction as set out in DVLA guidance for a class 1 licence but noting the thresholds for those with a class 2 occupational licence |  |
| This must be documented by attaching the visual field test results | |

**NB: surgery for chalazia or indications of ectropion or entropion no longer require prior approval for West Hampshire or North Hampshire CCG patients**

**To the best of my knowledge I have given the most accurate and up to date information regarding this patient’s clinical condition.  I have ensured that I have obtained consent from my patient or their legal representative /guardian to share their information with SCW CSU for the purposes of enabling full consideration of this funding request. All applications for Prior Approval are recorded and applicants may be held accountable for the information they submit.**

Yours sincerely

Referring/Treating clinician GMC Number