Trust/GP address

Date

IFR team

South, Central & West CSU

Omega House

112 Southampton Road

Eastleigh SO50 5PB

[scwcsu.ship.ifrrequests@nhs.net](mailto:scwcsu.ship.ifrrequests@nhs.net)

Dear team

Prior Approval– Hallux valgus (bunions)

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

Surgery for hallux valgus (bunions) should only be offered when **all** the following conditions have been met.

|  |  |
| --- | --- |
| The patient has been assessed through the MSK triage service and it ascertained they are likely to benefit from intervention. |  |
| Date of previous assessment:  Brief summary of previous interventions: | |

**AND**

|  |  |
| --- | --- |
| Has significant functional impairment related to the hallux valgus that is present more than half the time. |  |
| Please evidence the symptoms of the significant functional impairment (required): | |

**AND**

The impairment happens frequently over the preceding 30 days

**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