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– Carpal tunnel release/ nerve entrapment at wrist

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

May be considered under the following conditions;

|  |  |
| --- | --- |
| With moderate symptoms i.e. pins and needles in the day with occasional night symptoms (2-3 nights/week) where all conservative measures have failed and the symptoms have persisted for >6 months |  |
| Details of conservative measures tried (required) – wrist splint **and** a corticosteroid injection into the carpal tunnel (when these were offered and the benefit received):  Date of first presentation (required): | |

**OR**

|  |  |
| --- | --- |
| With severe symptoms where there is evidence of neurological deficit such as frequent pins and needles, numbness and permanent pain during the day, functional loss with muscle wastage and frequent nocturnal symptoms. |  |
| Please provide details (required): | |

**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