Trust/GP address

Date

IFR team

South, Central & West CSU

Omega House

112 Southampton Road

Eastleigh SO50 5PB

**scwcsu.ship.ifrrequests@nhs.net**

Dear team

Prior Approval– Palmar fasciectomy for Dupuytren’s contracture

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

Surgical management (palmar fasciectomy) for Dupuytren’s contracture should only be offered where there is **both** functional impairment **and** one of the following measured indications:

|  |  |
| --- | --- |
| Please confirm that there is significant functional impairment. | [ ]  |
| Please detail impairment here (required) |

**AND**

|  |  |
| --- | --- |
| Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint (MCPJ) or 20° at the proximal interphalangeal joint (PIPJ) resulting functional loss  | [ ]  |
| Please provide details of the contracture degree (required); |

|  |  |
| --- | --- |
| **OR** Severe thumb contractures which interfere with function | [ ]  |
| Please provide details of the contracture degree (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