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 – Functional endoscopic sinus surgery

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

Functional endoscopic sinus surgery is recommended as a treatment option ONLY for patients with chronic rhinosinusitis and/or nasal polyps in whom the following criteria are met:

|  |  |
| --- | --- |
| The patient has had severe and persistent symptoms despite treatment for at least twelve months. |  |
| Date of when first presented; | |

**AND**

|  |  |
| --- | --- |
| Symptoms have significantly impacted on quality of life despite optimal medical therapy. |  |
| Please detail the impact this has on QoL | |

**AND**

|  |  |
| --- | --- |
| The following medical therapies have been tried with inadequate response or are contra-indicated  Regular use of saline douching and nasal steroid **AND** |  |
| Please provide details of duration of use, response received or the contra-indication to its use; | |

For patients with nasal polyps attempts at medical polypectomy using a short course of prednisolone 0.5mg/kg and topical corticosteroid for 1 to 2 months, repeated at three-monthly intervals while patient shows response and provided there are no contra-indications **AND/ OR**

|  |
| --- |
| Please provide details of duration of use, response received or the contra-indication to its use; |

For patients with chronic rhinosinusitis, treatment with oral antibiotic (macrolide) for three months + douche + topical steroids.

|  |
| --- |
| Please provide details of duration of use, response received or the contra-indication to its use; |

**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