Trust/GP address

Date

IFR team

South, Central & West CSU

Omega House

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Dear team

Prior Approval– Ganglion excision

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

Ganglion cysts have a reasonable chance of spontaneous resolution and even if persistent cause no long-term adverse effects. Surgical excision should only be offered where aspiration has failed to resolve the ganglion or it is considered that its size or location would make aspiration inappropriate.

Approval for excision will only be considered in **one** of the following conditions:

|  |  |
| --- | --- |
| **Wrist ganglion** – the patient has significant neurological symptoms, restricted hand function only if aspiration fails to resolve the pain |  |
| Please detail (required) | |

**OR**

|  |  |
| --- | --- |
| **Seed ganglion (occurs at the base of fingers in palm of the hand)** – the patient has significant pain and loss of function with initial needle aspiration having failed |  |
| Please provide details of loss of function and details of when aspiration was attempted (required) | |

**OR**

|  |  |
| --- | --- |
| **Mucoid Cysts (formed just below the nail from the last joint in the finger)** – which has recurrent spontaneous discharges of fluid or causes disruption to the nail growth leading to significant functional impairment or pain |  |
| Please detail (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