Trust/GP address

Date

IFR team

South, Central & West CSU

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

Dear team

Prior Approval– Male circumcision

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

Male circumcision is not routinely funded but prior approval can be considered under one of the following conditions. Please indicate which of the following relates to your patient;

Pathological phimosis due to lichen sclerosus (formerly known as BXO) [ ]

Pathological phimosis due to balanitis/ balanoposthitis resistant to conservative treatment [ ]

Congenital urological abnormality where skin grafting is required [ ]

Recurrent splitting and scarring of the prepuce which affects sexual function and does not respond to at least two months of conservative management [ ]

|  |  |
| --- | --- |
|   |  |
| Please provide supporting documentation and **full details of all conservative treatments tried or confirm contra-indicated** **(required):** NB full details of conservative options are in the Priorities Committee policy statement |

**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