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– Varicose vein treatment

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

Treatments which may include venous ligation +/- stripping, phlebectomy, sclerotherapy or thermal techniques (laser/radio-thermal ablation) in varicose veins are not routinely funded.

Such treatments will only be considered for approval in the following circumstances:

|  |  |
| --- | --- |
| 1) Is the patient’s BMI less than 32 Yes  No |  |

|  |  |
| --- | --- |
| 2) Has there been either a first venous ulcer persisting >6 months despite conservative measures or a recurrent venous ulcer Yes  No |  |
| Please detail when ulceration first presented and conservative measures adopted: (required) | |

**OR**

|  |  |
| --- | --- |
| 3) A haemorrhage from a superficial varicosity Yes  No |  |
| Date and severity of bleed (required) | |

If you have answered No to question (1+2) or (1+3), then please confirm what are the exceptional circumstances and how this individual has an exceptional ability to benefit from the requested intervention over and above another individual with the same condition. (Please attach clinical photo if 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