

**FACET JOINT INJECTIONS - PRIOR APPROVAL FORM**

**Please ensure all sections are completed and any requested supporting information is provided to ensure a prompt decision. Unless the patient fully meets the criteria, funding will not be approved unless there are exceptional reasons.**

**PART A – MUST BE COMPLETED FOR ALL REQUESTS**

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| **GP/CONSULTANT DETAILS** |
| Name: |  | GP Practice Code: |  |
| Address: |  | Trust: |  |
| Preferred Contact (Email) - Only NHS.NET addresses are acceptable: |  @nhs.net |
| **PATIENT’S DETAILS** |
| NHS No: |  | MRN (if applicable): |  |
| Date of Birth: |  |

**Requesting clinician – please confirm the following**

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| Patient Consent: The Patient hereby gives consent for disclosure of information relevant to their case from professionals involved and to the CCG. | Yes  | No  |
| I have informed the patient that this intervention will only be funded where the criteria are met. | Yes  | No  |
| I confirm that I have reviewed the patient against the commissioning criteria and that the information provided within this application is accurate. | Yes  | No  |

**PART B – MUST BE COMPLETED FOR ALL REQUESTS**

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| **ACCESS CRITERIA** |
| The pain has lasted for more than 12 months in duration | Yes  | No  |
| **AND** the pain has resulted in moderate to significant impact on daily functioning or has pain rated at a level >6 on a scale of 0-10 (eg Pain visual analogue score/McGill Pain questionnaire) | Yes  | No  |
| **AND** conservative management options (advice to remain active/physiotherapy/exercise/appropriate pharmacotherapy) have been tried and failed **(PLEASE PROVIDE ADDITIONAL INFORMATION (See Note)****Please see over** | Yes  | No  |
| **AND** Must have been reviewed by a clinician specially trained in spinal assessment, diagnosis and management who considers that this treatment would enable mobilisation and/or participation in a rehabilitation programme. | Yes  | No  |
| **OR** Patient cannot tolerate medications and pain is significantly impacting on quality of life and activities of daily living **(PLEASE PROVIDE ADDITIONAL INFORMATION (See Note)** | Yes  | No  |

*Note: Significant functional impairment is defined by the CCG as:*

* + *Symptoms prevent the patient fulfilling vital work or educational responsibilities*
	+ *Symptoms prevent the patient carrying out vital domestic or carer activities*

**Please provide evidence below to support the information provided. Without evidence your application may be rejected. If you prefer you can attach supporting information, such as a clinic letter, rather than completing the box below.**

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| Supporting information: |

How to complete:

* Add GP/Consultant details
* Add Patient details
* Tick to answer yes or no to criteria listed under the procedure being requested
* Provide supporting information to evidence assessment in the free text area or attach supporting information such as clinic letter
* Email form to glccg.ifr@nhs.net
* Response will be sent from Gloucestershire CCG to preferred contact for reply within a maximum of 10 working days.