

**REMOVAL OF BENIGN SKIN LESIONS**

**- PRIOR APPROVAL FORM**

**(for Asymptomatic Skin Lesions please complete an IFR 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** | | |
| **Symptomatic Skin Lesions – Please provide further information as relevant** | | |
| Removal cannot be undertaken in Primary Care under the Minor Surgery Direct Enhanced Service because it is beyond GP surgical care or the Practice is not signed up to the Enhanced Service or the GP is unable to make an inter-practice referral. **(GP to provide further information at the time of application)** **AND** | Yes | No |
| Repeated infection, inflammation or discharge **OR** | Yes | No |
| Bleeding in the course of normal everyday activity **OR** | Yes | No |
| Obstruction of an orifice to the extent that function is impaired **OR** | Yes | No |
| Pressure symptoms eg on an organ, nerve or tissue **OR** | Yes | No |
| Its size or position is causing severe functional impairment of activities of daily living (details of the impact on daily living to be included in the application) | 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 details of the size of the lipomata***

**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: |

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| **FOR ASYMPTOMATIC SKIN LESIONS PLEASE USE THE IFR FORM** |

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| **Biopsies** |
| Biopsies are not covered by this policy and may be undertaken as required at the discretion of the managing clinician. |

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](mailto:glccg.ifr@nhs.net)
* Response will be sent from Gloucestershire CCG to preferred contact for reply within a maximum of 10 working days.