### APPENDIX C2

**Follow Up Appointments or Revision of Bariatric Surgery Funding Application**

**Effective April 2012**

This form must be completed for all requests for Follow Up Appointments or Revision of Bariatric Surgery. Requests **will not** be considered without a fully completed form and all relevant supporting documented evidence. Incomplete applications received will be returned to the requesting clinician.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details of Clinician submitting request and Patient** | | | | |
| **1. Details of clinician submitting the request** | **Name:** |  | | |
| **Designation:** |  | | |
| **NHS Trust or GP Practice:** |  | | |
| **Correspondence address:** |  | | |
| **Tel:** |  | | |
| **Email:** |  | | |
|  | | | | |
| **2. Patient details** | **Surname:** |  | | |
| **First name:** |  | | |
| **Address (including Postcode):** |  | | |
| **NHS Number:** |  | | |
| **Date of Birth:** |  | **Gender** |  |
| **Registered GP name:** |  | | |
| **Registered GP practice and postcode:** |  | | |

|  |  |
| --- | --- |
| **3. Which organisation will be providing the treatment requested?** | **Name of NHS Trust:** |

**Weight history**

**Date of Bariatric Surgery: Provider:**

**BMI Pre Surgery: BMI 6 months Post Surgery:**

|  |  |  |
| --- | --- | --- |
| **Current Weight (kg):** | **Height (m):** | **Current BMI:** |
| **3 months previously:** |  | **3 months previously:** |
| **6 months previously:** | **6 months previously:** |
| **9 months previously:** | **9 months previously:** |

The patient **must have** tried and failed to maintain weight loss over a **recent, continuous, 12 month period** using weight reduction programmes **for which documented evidence must be provided**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CRITERION** | **DETAILS** | **DATES** | **WEIGHT LOSS** | **EVIDENCE**  **ENCLOSED**  **(√)** |
| **Low and very low calorie diets** |  |  |  |  |
| **Exercise advice and programmes** |  |  |  |  |
| **Lifestyle modification** |  |  |  |  |
| **Dietary advice** |  |  |  |  |
| **Drug therapy** |  |  |  |  |

Does the patient have any of the following co-morbidities (please tick **ALL** that apply);

|  |  |
| --- | --- |
| **Established ischæmic heart disease** |  |
| **Type 2 diabetes requiring oral medication or insulin** |  |
| **Life threatening sleep apnoea** |  |
| **Severe uncontrolled hypertension** |  |
| **Benign intracranial hypertension** |  |
| **History of TIA or stroke** |  |
| **Severe lower limb major joint disease requiring orthopaedic intervention which is precluded on safety grounds due to the patient’s BMI. If yes, please give details:** |  |
| **Any other co-morbid condition which has been agreed by NHS Surrey as exceptional, on an individual patient basis** |  |

**Clinical criteria:**

|  |  |
| --- | --- |
| 1. **Has the patient been advised that a referral to a Specialised Weight Management Service cannot be made until authorisation of funding has been received from NHS Surrey?** | **Yes / No**  **Date patient was advised:** |
| 1. **Has the patient been advised that SEC PCT’s including NHS Surrey do not routinely fund skin reduction surgery or any cosmetic procedures following weight loss?** | **Yes / No**  **Date patient was advised:** |
| 1. **In your opinion, is the patient fit to have a general anaesthetic?**   **(Applies to requests for revision of bariatric surgery only)** | **Yes / No**  **If no, please give details:** |
| 1. **Have you advised the patient that there is a need long term follow up appointments?**   **(Applies to requests for revision of bariatric surgery only)** | **Yes / No**  **Date patient was advised:** |
| 1. **Does the patient have any specific psychological reasons why surgery may not be performed?**   **(Applies to requests for revision of bariatric surgery only)** | **Yes / No**  **If yes, please give details:** |
| 1. **Please give any further information you feel will be important in determining funding for this case, for example exceptional circumstances.** |  |

**I confirm that the information on this application form concerning the above patient is correct to the best of my knowledge.**

**Signature: Print Name:**

**Date:**

**Please email to:**

Safe Haven Email: **tnrf@nhs.net**

Or post to:

IFR/LPP/TNRF Team

NHS Surrey

Pascal Place, Randalls Research Park

Randalls Way, Leatherhead, Surrey KT22 7TW