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### APPENDIX B

**INTERVENTIONS INDIVIDUAL FUNDING REQUEST FORM – Effective April 2012**

***Please complete all sections and provide supporting information. Incomplete application forms received will be returned to the requesting clinician.***

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| **PART 1: DETAILS OF CLINICIAN SUBMITTING REQUEST AND PATIENT** | | | | | | |
| **1. Details of clinician submitting the request** | Name | |  | | | |
| Designation: | |  | | | |
| GP Practice: | |  | | | |
| NHS Trust: | |  | | | |
| Correspondence address: | |  | | | |
| Tel: | |  | | | |
| Email: | |  | | | |
|  | | | | | | |
| **2. Patient details** | Surname: | |  | | | |
| First Name: | |  | | | |
| Address (including Postcode): | |  | | | |
| NHS Number: | |  | | | |
| Date of Birth: | |  | | Gender: |  |
| Registered GP Name, Practice and Code: | |  | | | |
|  | | | | | | |
| **3. Instructions for communicating with the patient** | Does the patient or his/her representative wish to receive letters regarding this request? yes no | | | | | |
| If YES are the letters to be sent to the patient at the address above?  yes no | | | | | |
| If letters are to be sent to anyone other than the patient, please provide the following information, and obtain the patient’s written agreement: | | | | | |
| Name | |  | | | |
| Relationship to patient | |  | | | |
| Address (including Postcode) | |  | | | |
| **PART 2: INFORMED CONSENT AND PROVIDER TRUST APPROVAL** | | | | | | | |
| **4. Clinician’s affirmation of patient’s consent** | | I affirm that I have discussed this Individual Funding Request with my patient. This request is being made with his/her consent. The instructions for communicating with the patient at Q3 are his/her expressed wishes. | | | | | |
| Signature: | |  | | | |
| Name: | |  | | | |
| Designation: | |  | | | |
|  | | | | | | | |
| **5. Which organisation will be providing the treatment requested?** | | NHS Trust GP Practice Private sector Other | | | | | |
| Name of NHS Trust/GP Practice: | | | | | |
| If provider is outside the NHS, please give details of name and location | | | | | |
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| **6. If this funding request is approved, the NHS provider will be notified. Please give details for the person who should be notified:** | | Name of representative: | |  | | | |
| Designation: | |  | | | |
| Email address: | |  | | | |
| Postal Address: | |  | | | |

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| **PART 3: STATEMENT TO CONFIRM APPROPRIATENESS FOR CONSIDERATION AT IFR TRIAGE/IFR PANEL** | |
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| I confirm that it is not expected that there will be more than one patient from within the PCT population who is or is likely to be in the same or similar clinical circumstances as the requesting patient in the same financial year and who could reasonably be expected to benefit to the same or a similar degree from the requested treatment unless similar patients are expected to be from the same family group.  YES NO | |

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| **PART 4: DIAGNOSIS AND PATIENT’S CURRENT CONDITION** | | | |
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| **7. Diagnosis (for which the intervention is requested)** |  | | |
| **8. Has a second consultant opinion been obtained?** | If YES, please give details | | |
| **9. Current status of the patient:**  What is the patient’s clinical severity? (Where possible use standard scoring systems e.g. WHO, PASI, DAS scores, walk test, cardiac index etc.) |  | | |
| **10. Please summarise the current status of the patient in terms of quality of life, symptoms etc.** |  | | |
| **11. Summary of previous interventions for this condition**  Reasons for stopping may include:   * course completed * no or poor response * disease progression * adverse effects / poorly tolerated | Dates | Nature of intervention | Reason for stopping\*/ response achieved |
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| **PART 5: INTERVENTION FOR WHICH FUNDING IS REQUESTED** | | | | |
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| **12. Nature of the intervention**  If combination, tick all that apply | | Surgical procedure  Medical device  Therapy  Other (give details) | | |
| **13. Name of intervention** | |  | | |
| **14. Where will intervention be provided?**  Also indicate whether in-patient, out-patient, daycase | |  | | |
| **15. Is the requested intervention a continuation of existing treatment funded via another route?** | | YES NO  If YES, give details of existing funding arrangement and why ceased | | |
| **16. Is the intervention experimental, part of a trial or research?** | | YES NO - give details | | |
| **PART 6: INTERVENTIONS INVOLVING SURGICAL PROCEDURES, THERAPIES, DEVICES** | | | | |
|  | | | | |
| **17. Describe the intervention as it applies to this patient** | | |  | |
| **18. Is this intervention listed in the PCTs Low Priority Procedures (LPP) Policy?** | | | YES NO | |
| **19. Photographic evidence is required (with patient consent) to support applications for all external procedures (i.e. breast surgery, facial procedures, body contouring, skin lesions etc)** | | |  | |
| **20. Patients Body Mass Index (BMI)** | | |  | |
| **21. Specify any devices, prostheses, etc. and the manufacturer** | | |  | |
| **22. Estimated costs** | | | Anticipated cost (inc VAT) |  |
| Are there any offset costs? | YES NO |
| Describe the type and value of offset costs |  |
| Funding difference being applied for: |  |
|  | | | | |
| **PART 7: PROJECTED OUTCOMES** | | | | |
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| **23. Is there a standard intervention for this patient at this stage of their condition?**  If so, please describe the standard intervention |  | | | |
| **24. What would be the expected outcome from the standard intervention?** |  | | | |
| **25. Why is the standard intervention inappropriate for this patient?** |  | | | |
| **26. What would you consider to be a successful outcome for the requested intervention in this patient?** | This may include likely OS, TTP or improvement in QOL. Please relate to measures describing patient’s condition in Part 4. | | | |
| **27. Please outline any anticipated or likely adverse effects of the requested treatment for this patient** |  | | | |
| **28. How would you monitor the effectiveness of the requested intervention?** | Please refer to the measures used to describe the patient’s condition in Part 4 | | | |
| **29. What is the minimum timeframe/course of treatment after which a clinical response can be assessed?** |  | | | |
| **30. What are the likely clinical consequences for the patient if this request is not approved?** |  | | | |
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| **PART 8: STATEMENT OF EXCEPTIONALITY OR RARITY** | |
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| **31. On which basis are you making this request?** | Exceptional clinical circumstances  OR  Rarity of condition or presentation |
| **32. For exceptional clinical circumstances, please describe as clearly as possible why the patient’s clinical circumstances are exceptional.**  **You must give specific information to indicate how this patient is significantly different to the population considered in the existing policy.**  **Psychological distress does not make a case exceptional.** | |
| **33. For rarity of condition or presentation, please describe as clearly as possible why this patient’s condition or clinical presentation is so unusual that there is no relevant commissioning arrangement.** | |

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| **PART 9: EVIDENCE OF CLINICAL EFFECTIVENESS** |
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| **34. Give details of published data supporting the use of the requested intervention for this condition.** Please provide references or attach articles. |
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| **PART 10: URGENCY** |
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| **35. Only a small minority of requests can be decided using the PCT’s fast-track procedure. If there are compelling clinical reasons why this patient’s request should be fast-tracked, please state them here.** |

Thank you for completing this form.

Please send as an electronic attachment to [tnrf@nhs.net](mailto:tnrf@nhs.net)

Alternatively, post to;

IFR/LPP/TNRF Team, NHS Surrey

Pascal Place

Randalls Research Park

Randalls Way

Leatherhead

Surrey

KT22 7TW