**FEMALE BREAST REDUCTION (ASYMMETRY) - 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**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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**

|  |  |  |
| --- | --- | --- |
| Patient Consent: The Patient hereby gives consent for disclosure of information relevant to their case from professionals involved and to the ICB. | 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**

|  |  |  |
| --- | --- | --- |
| **ACCESS CRITERIA** | | |
| There is an impact on health as per the criteria below:   * Thoracic/shoulder girdle discomfort (physiotherapy assessment has been provided) * Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps) | Yes | No |
| **AND** There is a difference in breast size of 150 – 200gms size as measured by a specialist. | Yes | No |
| **AND** The patient’s BMI is <27 and stable for at least twelve months. | Yes | No |

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation.

**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.**

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