**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**

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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 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**

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| **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.**

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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 glicb.ifr@nhs.net
* Response will be sent from Gloucestershire ICB to preferred contact for reply within a maximum of 10 working days.