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| **PRIOR APPROVAL****REQUEST FORM** |



Please only use this form when **all** treatment optional available within locally provided services have been exhausted and it is **clinically appropriate** to consider accessing healthcare services elsewhere. Please note, only **typed** forms will be accepted.

**Clinical Board Director: Clinical Director:**

**………………………………** (name)  **………………………………** (name)

**……………………………** (e-signature)  **……………………………** (e-signature)

**………………………………** (date of e-signature) **………………………………** (date of e-signature)

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| **Details of clinician making the referral:** | **Details of clinician patient is being referred to:** |
| Name: | Name: |
| Designation: | Specialty: |
| Address: | Address: |
| Postcode: | Postcode: |
| Telephone number: | Telephone number: |
| Fax number:  | Fax number:  |
| Email: | Email: |

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| **Patient Details** |
| Forename:  | Surname:  |
| Address: | Date of birth: |
| Telephone number: |
| NHS number: |
| Postcode: | Hospital number: |

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| **Urgency**   |
| How urgent is the request? (tick as applicable) | **Urgent:**24-48 hours | **Soon:**Within 3 weeks  | **Non-urgent:**4-6 weeks  |
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**Please note:** If a decision is required urgently, clinical reasons must be provided. Administrative reasons will not be considered.

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| **Reason for request**  |
| * Second opinion
* Lack of local expertise/ commissioned service provision
* Clinical continuity of care
* Transfer back to the NHS following self-funding in the private sector
* Re-referral following a previous tertiary referral
* Student
* Veteran
* Other- please specify
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| **Clinical details** |
| Details of treatment requested: |
| Medical history and current clinical status:(Please provide a copy of the latest clinical report)   |
| What plans are in place to ensure the patient is returned to local services following the treatment/intervention requested? |
| Has advice been sought from other colleagues or neighbouring Health Boards with whom we hold a contract (please provide details)  |
| Additional information to support the referral:(clinical letters/reports should be attached)  |
| Cost of treatment: |

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| I confirm that as the patients Consultant/GP, I have discussed this application and consent has been provided to obtain further clinical information pertinent to this funding request if required. **Clinicians signature:** **Date:**  |
| **Please return this form with a copy of the referral letter to:**Cardiff and Vale IPFR Team, Cardiff and Vale University Health Board, Woodland House, 2nd Floor, Maes-y-Coed Road, Cardiff, CF14 4HH. Telephone 02921836535 or email CAV.IPFR@wales.nhs.uk |