Derby and Derbyshire
Clinical Commissioning Group

Derbyshire PLCV Referral Form

Surgical Treatment for Sleep Apnoea

THIS FORM MUST BE COMPLETED IN FULL AND ATTACHED WITH THE APPROPRIATE CLINICAL INFORMATION TO THE E-REFERRAL SERVICE
"PLCV: - DERBYSHIRE PRIOR APPROVAL PROCESS: SLEEP APNOEA_RAS"

REFERRALS WITHOUT FORMS WILL BE REJECTED

Patient details
Surname
Forename(s)
Address **Post code**
Date of birth
NHS Number

Referring GP details
Referring GP
Practice name
Practice address **Post code**
Telephone number
GP practice code

Patient Consent	
	Mark or tick boxes below to confirm
I confirm the patient has consented to sharing personal and clinical information contained within this referral form. The Derbyshire Prior Approval Team will process this information, clarify data and communicate with the patient and the GP on the outcome.	☐
By submitting this request you are confirming that you have reviewed this request against relevant policy and believe the patient meets the relevant threshold criteria and therefore you have fully explained to the patient the proposed treatment and they have consented to you raising this referral on their behalf.	☐
Please confirm that you have given PLCV patient leaflet to the patient	☐

Part A - PLCV Criteria	At least ONE must apply
The Commissioner will fund a referral from primary care surgical treatment of sleep apnoea if :	
Referral has been made to a weight management service where the patient is overweight or obese* (*Overweight or obese is over 25 BMI)	☐

Additional clinical information that may have a bearing on the application

Additional Patient Information	BOTH must apply
This patient is willing to undergo a surgical procedure should it be offered.	☐
I have discussed with the patient the fact they will be referred for a possible procedure but there is no guarantee that a surgical intervention will be the required outcome following the consultation with the secondary care specialist.	☐

Prior Approval No	

Patient Choice of Provider	
First Choice:	[Manually enter provider name]
Second Choice:	[Manually enter provider name]

I confirm that the patient meets the current clinical guideline/policy for referral for the procedure.

Name of referrer: _____ Date: _____

Part B – Reason for referral	
Salutations: Preamble/context:	Dear colleague, Macro to insert last consultation Thank you, Dr. XXX (insert your name here)

Problems - This needs to be auto pulled from the GP system

Relevant SH & FH:

Date to be included Smoking status Alcohol Occupation Ethnicity Veteran? **Freetext:** Detail which might assist timely discharge:	Single Code Entry: Tobacco consumption Single Code Entry: Alcohol consumption Single Code Entry: Occupations Single Code Entry: Ethnic category - 2001 census Single Code Entry: Military veteran

Medication – Date to be included. The GP's need to have the option to EDIT this once it has been populated.

Allergies – Date to be included . The GP's need to have the option to EDIT this once it has been populated.

Useful values:

BP	**Pulse rate**	**Height**	**Weight**	**BMI**	**HbA1C**
Single Code Entry: O/E - blood pressure reading Date	Single Code Entry: O/E - pulse rate	Single Code Entry: O/E - height	Single Code Entry: O/E - weight	Single Code Entry: Body mass index	Date

Please embed any attached items here.
Please note any individual patient requirements here (e.g. Wheelchair user).