NHS
Derby and Derbyshire
Clinical Commissioning Group

Derbyshire PLCV Referral Form

Varicose Veins

THIS FORM MUST BE COMPLETED IN FULL AND ATTACHED WITH THE APPROPRIATE CLINICAL INFORMATION TO THE E-REFERRAL SERVICE
"PLCV: - DERBYSHIRE PRIOR APPROVAL PROCESS: SURGERY NOT OTHERWISE SPECIFIED_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	
The CCGs will only fund surgical treatment of varicose veins when **ONE** of the following criteria are met:	**ONE or more must apply**
• Lower limb skin changes thought to be caused by chronic venous insufficiency such as pigmentation or eczema.	☐
• Superficial thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.	☐
• A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks – suggesting that there is an underlying arterial or venous disease) secondary to varicose vein.	☐
• A healed venous leg ulcer	☐

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.	☐

Additional clinical information that may have a bearing on the application

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:	Dear colleague,
Preamble/context:	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	Single Code Entry: Tobacco consumption
Smoking status	Single Code Entry: Alcohol consumption
Alcohol	Single Code Entry: Occupations
Occupation	Single Code Entry: Ethnic category - 2001 census
Ethnicity	Single Code Entry: Military veteran
Veteran?	
Freetext:	

Detail which might assist timely discharge:	

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).