

Derbyshire PLCV Referral Form

Surgical Haemorrhoidectomy

THIS FORM MUST BE COMPLETED IN FULL AND ATTACHED WITH THE APPROPRIATE CLINICAL INFORMATION TO THE E-REFERRAL SERVICE

“PLCV: - DERBYSHIRE PRIOR APPROVAL PROCESS: GI AND LIVER (MEDICAL AND SURGICAL)_RAS”

REFERRALS WITHOUT FORMS WILL BE REJECTED

Patient details	Referring GP details
Surname	Referring GP
Forename(s)	Practice name
Address	Practice address
Post code	Post code
Date of birth	Telephone number
NHS 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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
Please confirm that you have given PLCV patient leaflet to the patient	<input type="checkbox"/>

Part A - PLCV Criteria	One Must apply
<p>The Commissioner will only fund treatment or Surgical Haemorrhoidectomy if indication A or B is met:</p>	
<p>A. Recurrent (grade 3 persistent symptomatic haemorrhoids that fails to respond to conservative treatment. Patients should be recommended to try the following options in primary care:</p> <p>Oral Fluid Intake, high fibre diet and fibre supplementation Topical Treatment Rubber band ligation (dependent on training and equipment availability within primary care / however would also be carried out by secondary care)</p>	<input type="checkbox"/>
<p>B. Haemorrhoids that cannot be successfully reduced and where banding is not appropriate.</p> <p>Does the patient have recurrent grade 4 combined internal/external with persistent pain and bleeding.</p>	<input type="checkbox"/>

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.	<input type="checkbox"/>
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.	<input type="checkbox"/>

Prior Approval No	
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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.
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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 Single Code Entry: O/E - blood pressure reading Date	Pulse rate Single Code Entry: O/E - pulse rate	Height Single Code Entry: O/E - height	Weight Single Code Entry: O/E - weight	BMI Single Code Entry: Body mass index	HbA1C Date
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Please embed any attached items here.

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