NHS
Derby and Derbyshire
Clinical Commissioning Group

Derbyshire PLCV Referral Form

Meibomian (Chalazion) cyst removal

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

REFERRALS WITHOUT FORMS WILL BE REJECTED

Patient details	Referring GP details
Surname	Referring GP
Forename(s)	Practice name
Address Post code	Practice address
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.	☐
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	
Incision and curettage of chalazia should only be undertaken if TWO or more of the following criteria have been met:	
	At least TWO of the following criteria must apply
• The chalazion/ chalazia have been present for more than six months	☐
• The chalazion/ chalazia has/ have been managed conservatively with warm compresses, lid cleaning and massage for at least FOUR weeks	☐
• Vision is significantly impaired	☐
• Lid closure is affected, therefore compromising eye protection	☐
• The chalazion/ chalazia is/ are infected and creating an abscess	☐
• The chalazion/ chalazia is/ are infected, requiring medical attention on two or more episodes in the last six months.	☐
Exclusion Criteria – Where malignancy is suspected referral for specialist opinion may be sought (under 2ww as deemed appropriate). Presence of a red eye may indicate blepharokeratoconjunctivitis (BKC) – Referral to ophthalmology is advised.	

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, ${Current_Consultation} Thank you, ${Referring_doctor}

Problems

${Major_Active_Problems}

${Minor_Active_Problems}

Relevant SH & FH:

Date	${Todays_date}
Smoking status Alcohol Occupation Ethnicity Veteran?	${RC_XE0og} ${RC_Ub0ID} ${RC_0….} ${RC_ XaJQu} ${RC_ XaX3N}
Detail which might assist timely discharge:	

Medication – ${Todays_date}

${Current_Acute_Issues}

Allergies – ${Todays_date}

${Allergies}

Useful values:

BP	**Pulse rate**	**Height**	**Weight**	**BMI**	**HbA1C**
${RC_246..} **Systolic BP** ${RC_2469.} **Diastolic BP** ${RC_246A.} ${Todays_date}	${RC_242..}	${RC_229..}	${RC_22A..}	${RC_22K..}	${RC_X772q} ${Todays_date}

Please embed any attached items here.

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