

Vaginal/Uterine Prolapse

BEFORE providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate **EXPLICIT CONSENT** for sensitive and personal information on this form to be passed to the Funding Team/CCG/CSU for processing.

Consent given: Yes

Please ensure a secure NHSmail email account (nhs.net) is used to submit this form.

Patient First name		Patient Surname		Hospital	
NHS No.		Date of Birth		Consultant	
GP F-code		CCG		UBRN	
Hospital No.		Referrer			

Additional information

Please submit completed form to the following email address:

bbccg.mseccg-funding@nhs.net

A decision will be made and the form returned within **3 working days** where all relevant information is provided.

N.B: Please ensure forms are clear and legible. Illegible forms will be returned to sender.

Initially, patients should be assessed and managed conservatively in primary care. **Please refer to page 145 of the M&SE STP Value Based Commissioning Policy for guidance on vaginal pessaries and surgery.**

Patients can only be referred for funding if they meet ONE of the following sets of criteria. Please indicate which of the criteria the patient meets:		Please Tick ✓
	<ul style="list-style-type: none"> In cases of <u>mild to moderate</u> symptomatic cystoceles where trial of a pessary has failed. 	
OR	<ul style="list-style-type: none"> In cases of <u>mild to moderate</u> symptomatic rectoceles. 	
OR	<ul style="list-style-type: none"> In <u>severe</u> cases of prolapse or precdential. 	

Please supply information clearly evidencing the selected criteria above



CCG USE:	Invoice ref:	Prior Authorisation requested by:	
Is the procedure approved or declined? <small>Please indicate:</small>		Name of Clinician	
Name		Contact number	
Signature		Date	