Adenoidectomy-Adjuvant

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 Name		**GP Surgery**			
GP F-code		**CCG**		**UBRN**	
Hospital No.		**Referrer**			

Additional information

Please submit completed forms to the following email addresses:

- **For South Essex patients:** fundingrequests.south@nhs.net
- **For Mid Essex patients: if you are the referring GP/Nurse please send to** central.referral@nhs.net
  If you are the referring consultant please send to MECCG.IFR@nhs.net

A decision will be made and an outcome letter will be sent 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.

Patients can only be referred for funding if they meet TWO of the following sets of criteria. Please indicate which of the criteria the patient meets: ****Adenoidectomy as a separate procedure will not be funded****		**Please Tick ✓**
A **AND**	• Children 18 years of age or under	
B **OR**	• With Otitis Media with Effusion (OME) who meet the CCG commissioning criteria for ventilation tubes (grommets) and in the presence of persistent and/or frequent upper respiratory tract infections (see Grommets)	
C	• Children where obstructive sleep apnoea (OSA) is demonstrated by sleep study or diagnosed clinically in the presence of excessively large tonsils and adenoids with documented evidence of failure to thrive assessed as per NICE guidance- NG 75 (see Tonsillectomy)	

Please supply full supporting information clearly evidencing how the patient meets policy criteria

<table>
<tr><td>CCG USE:</td><td>Invoice ref:</td><td colspan="2">Prior Authorisation requested by:</td></tr>
<tr><td colspan="2">Is the procedure approved or declined?
Please indicate:</td><td>Name of Clinician</td><td></td></tr>
<tr><td>Name</td><td></td><td>Contact number</td><td></td></tr>
<tr><td>Signature</td><td></td><td>Date</td><td></td></tr>
<tr><td>Date</td><td></td><td></td><td></td></tr>
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