Arthroscopy Knee

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.

Please tick which knee requires procedure

Left ☐ **Right** ☐

Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag* symptoms/signs/conditions/ reason) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

***Red flag symptoms or signs include recent trauma, constant progressive non- mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.**

	Patients can only be referred for funding if they meet <u>ONE OR MORE</u> of the following criteria. Please indicate which of the criteria the patient meets:	**Please Tick ✓**
	• Removal of loose body where there is a clear history of locking and other treatment has failed	
<u>OR</u>	• Meniscus resection/meniscectomy or meniscus repair	
<u>OR</u>	• Articular cartilage debridement/chondroplasty or microfracture of chondral defect	
<u>OR</u>	• Anterior or posterior ligament reconstruction-primary or revision	
<u>OR</u>	• Synovectomy / symptomatic plica	
<u>OR</u>	• To assist selection of appropriate patients for uni-compartmental knee replacement	
<u>OR</u>	• Treatment of osteoarthritis with arthroscopic lavage (washout) and debridement only if the person has knee osteoarthritis with a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies)	
<u>OR</u>	• Continuing diagnostic uncertainty following MRI, but only in one or more of the following circumstances: ○ When the MRI is of low quality and cannot be interpreted ○ The report shows a significant degree of movement artefact ○ Where the patient has had an Anterior Cruciate Ligament ○ Reconstruction and the metal screws are affecting the image quality ○ Patient has a pacemaker	

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

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

Date	