Hip Joint Injections

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.

M&SECCGs commission hip joint injections under imaging guidance on a restricted basis.

Current evidence on the safety and efficacy does not appear adequate to routinely recommend hip joint injections.

Please tick which hip requires procedure:

Left **Right**

Patients can only be referred for funding if they meet ONE or more of the criteria below. **Please indicate that the patient meets the below criteria :**		**Please Tick ✓**
	• Diagnostic aid.	
OR	• To introduce contrast medium to the joint as part of hip arthrogram.	
OR	• Investigation of infection in biological and replaced hips.	

OR	• Adults with inflammatory arthropathy.	

Please supply information clearly evidencing the selected criteria above

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			