Hip Resurfacing

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.

Please tick which hip requires procedure
(Please complete separate forms for bilateral requests)

Left ☐ **Right** ☐

Patients can only be referred for funding if they meet the criteria below. **Please indicate that the patient meets the criteria:**	**Please Tick ✓**
• M&SECCGs will only fund those patients who would qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing.	

https://www.nice.org.uk/guidance/ta304/resources/total-hip-replacement-and-resurfacing-arthroplasty-for-endstage-arthritis-of-the-hip-review-of-technology-appraisal-guidance-2-and-44-82602365977285
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Hip resurfacing is not generally considered the best option for women over the age of 65. Clinicians applying for funding approval should provide full clinical rationale for choice.

Prostheses for resurfacing arthroplasty are recommended as a treatment option for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Please supply information clearly evidencing the selected criteria above

(where applicable)

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			