# Labial Reduction/Refashioning/Vaginoplasty/Cliteroplasty

**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.

**This policy does not apply to genital reconstruction for gender dysphoria as CCGs are not the responsible commissioners. NHS England is responsible for commissioning gender identity disorder services from Specialist Gender Identity Disorder Clinic Centres.**

**M&SECCGs do not fund elective vaginal labia reduction/refashioning or hymenorrhaphy or vaginoplasty or cliteroplasty as these are considered to be cosmetic procedures.**

| **Patients can only be referred for funding if they meet ONE of the criteria below.**<br>**Please indicate which of the criteria the patient meets:** | | **Please Tick ✓** |
|---|---|---|
| | • Vaginoplasty for congenital absence, significant developmental/endocrine abnormalities of the vaginal canal or post-traumatic vaginal stenosis. | |
| **OR** | • Reconstructive surgery for patients who have undergone female genital mutilation or cutting. | |

**Labia repair trauma**

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| Repair of labia at the time of trauma will be routinely funded.<br>Post immediate trauma applications will not be funded unless there are **exceptional clinical circumstances.** |

| **Please supply information clearly evidencing the selected criteria above**<br>**** In all circumstances medical photography is required with the funding request submission **** |
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| |

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