Arthroscopic Shoulder Decompression

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 Name		**CCG**		**Hospital No.**	
NHS No.		**GP Practice Code**		**UBRN:**	
Date of Birth		**Referrer**		**Consultant**	

Additional information

Please submit completed forms to the following email addresses:

- **For South Essex patients: fundingrequests.south@nhs.net**
- **For Mid Essex patients: rachel.anderson8@nhs.net or clarebrown4@nhs.net**

A decision will be made and the form returned within 3 working days.

N.B: Please ensure forms are clear and legible. Any forms that are illegible will be returned to sender.

M&SECCGs commission arthroscopic shoulder decompression on a restricted basis. Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases. To be clear-'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calicific tenidinopathy. **Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.**

Patients can be considered for surgical opinion for patients who meet all of the following criteria:		✓
	• Patient has had symptoms for at least 3 months from the start of treatment	
AND	• Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat)	
AND	• Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks	
AND	• Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management	
AND	• Referral is at least 8 weeks following steroid injection	
AND	• Patient confirms they wish to have surgery.	

Please supply information clearly evidencing the selected criteria above:

Prior Authorisation requested by:		Procedure authorised/declined by:	
Name of Clinician		Name	
Contact number		Signature	
Date		Date	

REFERENCE (for invoice purposes)	