**INDIVIDUAL FUNDING REQUEST**

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| LOW PRIORITY TREATMENT PANEL  Notes for completion  This application is to be used for procedures of limited clinical benefit which are not routinely commissioned.  This application must be completed electronically. Handwritten applications will be returned.  It is the referring clinician’s responsibility to ensure that the application is completed as accurately and comprehensively as possible. This includes full copies of any supporting clinical research evidence. Incomplete forms providing insufficient information will be returned.  Further information, including panel dates, can be found in the Individual Funding for Treatments Policy, available on the NHS Kernow website <http://www.kernowccg.nhs.uk/get-info/individual-funding-requests/> | | |
| 1 Patient details | | |
| Name: |  | |
| Dob: |  | |
| Address: |  | |
| NHS no: |  | |
| 2 Details of the treatment/procedure for which funding is being requested | | |
|  | | |
| 3 Referring clinician details | | |
| Name: |  | |
| Address: |  | |
| Phone: |  | |
| GP name  (if not referrer): |  | |
| Is GP aware of  referral: |  | |
| 4 Diagnosis and details of the patient’s present condition | | |
|  | | |
| 5 Details of relevant past medical history and care already received | | |
|  | | |
| 6 Full cost of treatment | | |
|  | | |
| 7 Details of the benefit this treatment will bring | | |
|  | | |
| 8 Why is this treatment preferable to any other available? | | |
|  | | |
| 9 Summary of evidence for the treatment | | |
|  | | |
| 10 Patient measurements (see appropriate policy for details) | | |
|  | | |
| EXCEPTIONAL CLINICAL NEED (PART 1)  Please note the NHS Kernow policy on the relevance of non-clinical factors. The panel does not routinely consider social issues, for example, employment, when identifying exceptional clinical need. | | |
| How is the patient significantly different to the general population of patients with the condition in question?  PROVIDE EVIDENCE TO SUPPORT OPINION  eg. photos/assessments | |  |
| EXCEPTIONAL CLINICAL NEED (PART 2) | | |
| How is the patient likely to gain significantly more benefit from the intervention than might normally be expected for patients with this condition? | |  |
| Signature of the referrer | | |
| Signing this form confirms that   * you have advised the patient that this treatment is not normally funded by NHS Kernow * the patient understands they are giving consent for information from their medical record to be viewed by the IFR team and panel * you have given the patient the leaflet ‘Will the NHS fund my treatment?’, which explains how their confidential data is used   (see website for leaflet) <http://www.kernowccg.nhs.uk/get-info/individual-funding-requests/>  Sign:  Print name:  Date: | | |

Please submit this form (with supporting information) to:

Individual Funding Requests **Tel** 01726 627 964

NHS Kernow **Fax** 01726 627 899

Sedgemoor Centre **email** [KCCG.IFRequests@nhs.net](mailto:KCCG.IFRequests@nhs.net)

Priory Road **website** [www.kernowccg.nhs.uk](http://www.kernowccg.nhs.uk)

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