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| **Additional information** |
| **Please submit completed form to the following email address:**  [**mseicb.ifrfunding@nhs.net**](mailto:mseicb.ifrfunding@nhs.net)  **A decision will be made, and the form returned within 3 working days where all relevant information is provided.** |

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| **Mid and South Essex ICB commissions surgery for breast reduction on a restricted basis.**  Procedures for cosmetic purposes only will not be funded.  Women and people capable of pregnancy should be informed that breast surgery for hypermastia can cause permanent loss of lactation. They must be provided with written information to allow them to balance the risks and benefits of breast surgery.  **Initial assessment must be done by the GP prior to referral to ensure criteria a) to g) are met.**  Contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any post-surgical cosmetic irregularities will not be funded by the ICB in revision surgery |

**Breast Reduction**

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| **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 M&SE Integrated Care Board for processing.  **Consent given:**   **Please tick)**  Please ensure a secure NHSmail email account (nhs.net) is used to submit this form. | | | | | | |
| **Patient First name** | Click here to enter text. | **Patient Surname** | Click here to enter text. | | **Hospital** | Click here to enter text. |
| **NHS No.** | Click here to enter text. | **Date of Birth** | Click here to enter a date. | | **Consultant** | Click here to enter text. |
| **GP F-code** | Click here to enter text. | **Patient locality/area**  **i.e. Mid Essex, Southend** | | Click here to enter text. | | |

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| **Breast reduction will be funded if ALL the following criteria are met**  **Please indicate the patient meets the criteria:** | | **Please Tick**  **** |
|  | 1. Woman/ person assigned female at birth are aged at least 18 years. |  |
| **AND** | 1. The patient has received a full package of supportive care from their GP such as advice on weight loss and managing pain |  |
| **AND** | 1. In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided.   **Please confirm date**  Click here to enter text. |  |
| **AND** | 1. Breast size results in functional symptoms over at least 12 months that require other treatments/interventions (e.g., intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). Clinical evidence will need to be produced to rule out any other medical/physical problems to cause these symptoms.   **Please give details below:**  Click here to enter text. |  |
| **AND** | 1. The patient has body mass index (BMI) is <27kg/m2 and evidence that the weight has been stable for 12 months   **Please give details below:**  Click here to enter text. |  |
| **AND** | 1. At least 1kg is planned to be removed from each breast |  |
|  | 1. The patient is a non-smoker at the time of referral (confirmed by CO reading).   **Please confirm C02 reading:**  Click here to enter text. |  |

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| **PLEASE SIGN AND DATE THIS BOX: Funding approval is requested by** | |
| **Name of Clinician** | Click here to enter text. |
| **Contact number** | Click here to enter text. |
| **Date** | Click here to enter a date. |

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| **FOR ICB COMPLETION ONLY** | |
| **DECISION:**  Choose an item. | |
| **Name** | Click here to enter text. |
| **Signature** | Click here to enter text. |
| **Date** | Click here to enter a date. |
| **Reference number** | Click here to enter text. |