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| **Additional information** |
| **Please submit completed form to the following email address:****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 unilateral breast reduction surgery for breast** **asymmetry on a restricted basis**Procedures for cosmetic purposes only will not be funded. Funding will only be considered if there is gross disparity of breast cup sizes i.e., asymmetry where there is at least 2 cup size difference in breast size on initial consultation with the patient’s GP.**Only unilateral breast reduction (not unilateral breast augmentation) will be funded.**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 Asymmetry**

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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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| **Patients are eligible for surgery to correct breast asymmetry if ALL the following** **criteria are met and confirmed by a consultant plastic or breast surgeon:****Please indicate the patient meets the criteria:** | **Please Tick****** |
|  | * Clinical evidence rules out any other medical problems to cause this

Presentation **Please give details below:** Click here to enter text. | [ ]  |
| **AND** | * There is no ability to maintain a normal breast shape using non-surgical

methods (e.g., padded bra) **Please give details below:** Click here to enter text. | [ ]  |
| **AND** | * There is a difference of at least 2 cup sizes (e.g., C and DD cup size

differential) **Please state cup sizes**:  **Left:**  Click here to enter text. **Right:**  Click here to enter text. | [ ]  |
| **AND** | * The patient has had no change in cup size for 1 year as documented in

patient’s clinical records. **Please give details below:** Click here to enter text. | [ ]  |
| **AND** | * Where relevant, treatment of the underlying cause of the problem has been undertaken.

 **Please give details below:** Click here to enter text. | [ ]  |
|  | * 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. |