**Male Sterilisation (Vasectomy)**

**under General Anaesthetic**

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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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| **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 male sterilisation (Vasectomy) under General Anaesthetic on a restricted basis.****Counselling: the patient must be aware that the procedure is permanent but has a failure rate, and that reversal is not funded on the NHS (Unless there are Exceptional Clinical Circumstances).** Please refer the Mid & South Essex Service Restriction Policy for further details. |

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| **Vasectomy under General Anaesthetic (GA) will only in the following circumstances:** | **Please tick****** |
|  | * Previous documented adverse reaction to local anaesthesia

**(Please provide details in the evidence box below)** | [ ]  |
| **OR** | * Scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or control of the spermatic cord through the skin difficult to achieve.

 **(Please provide details in the evidence box below)** | [ ]      |

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| **Please supply information clearly evidencing the selected criteria above:** |
| 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. |