PRIOR APPROVAL REQUEST FORM

Proposed: V2 March 2022

Please only use this form when **all** treatment options available within locally provided services have been exhausted and it is **clinically appropriate** to consider accessing healthcare services elsewhere.

Please complete the form **electronically**. All illegible and incomplete forms will be returned. Handwritten forms, incomplete forms and unsigned forms will be returned.

Details of clinician making the referral:	**Details of clinician patient is being referred to:**
Name:	Name:
Designation:	Specialty:
Address:	Address:
Postcode:	Postcode:
Telephone number:	Telephone number:
Fax number:	Fax number:
Email:	Email:

Patient Details	
Forename:	Surname:
Address:	Date of birth:
	Telephone number:
	NHS number:
Postcode:	Hospital number:

Urgency			
How urgent is the request? (tick as applicable)	**Urgent:** 24-48 hours	**Soon:** Within 3 weeks	**Non-urgent:** 4-6 weeks
Please note: If a decision is required urgently, clinical reasons must be provided. Administrative reasons will not be considered.			

Reason for request – **Refer to Part 5 of the NHS Wales Prior Approval Policy 2018**	
	Second Opinion
	Lack of local/commissioned service provision/expertise
	Clinical continuity of care
	Transfer back to the NHS following self-funding in the private sector
	Re-referral following a previous tertiary referral
	Student
	Veteran
	Other – please specify:

Clinical details
Details of treatment requested:

Medical history and current clinical status:
(Please provide a copy of the latest clinical report)

What plans are in place to ensure the patient is returned to local services following the treatment/intervention requested?

Has advice been sought from other colleagues or neighbouring Health Boards with whom we hold a contract (please provide details) (Please confirm with Clinical Leads or Contracting Team if necessary before completion):

Additional information to support the referral:
(Please provide copies of all relevant clinical information, eg Referral letters; Clinical history; CMATS, MDTs):

Cost of treatment:

*Please indicate (number of items * unit cost) where relevant :*	**Cost**
Assessment / Consultation	
MDT	
Pre-op	
Procedure (please specify)	
Post-op follow-up(s)	
Other (please state)	
TOTAL COST applied for =	

I confirm that as the patients Consultant/GP, I have discussed this application and consent has been provided to obtain further clinical information pertinent to this funding request if required.
Requests for funding will not be accepted without the applicants signature (can be added electronically)

Clinician's signature:
Date:

Please return this form with copies of all relevant clinical information to:

Planning.office@wales.nhs.uk

Please direct any queries to the IPFR Team at the email above or via:
Tel: 01639 683615