Arthroscopy Hip including Femoro-Acetabular Impingement (FAI)

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 Funding Team/CCG/CSU for processing.

Consent given: Yes ☐

Please ensure a secure NHSmail email account (nhs.net) is used to submit this form.

Patient First name		**Patient Surname**		**Hospital**	
NHS No.		**Date of Birth**		**Consultant**	
GP Name		**GP Surgery**			
GP F-code		**CCG**		**UBRN**	
Hospital No		**Referrer**			

Additional information

Please submit completed forms to the following email addresses:

- **For South Essex patients: fundingrequests.south@nhs.net**
- **For Mid Essex patients: if you are the referring GP/Nurse please send to central.referral@nhs.net**
  If you are the referring consultant please send to MECCG.IFR@nhs.net

A decision will be made and an outcome letter will be sent within 3 working days where all relevant information is provided.

N.B: Please ensure forms are clear and legible. Illegible forms will be returned to sender.

Please tick which hip requires procedure

Left ☐ **Right** ☐

Patients can only be referred for funding if they meet ALL of the following criteria. Please indicate the patient meets the criteria:		**Please Tick ✓**
	• Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans.	
AND	• An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist.	
AND	• Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above.	

AND	• Failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy.	
AND	• Compromised function, which requires urgent treatment within a 6-8 months' time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date.	
AND	• Treatment with more established surgical procedures is not clinically viable.	

Please supply full supporting information clearly evidencing how the patient meets policy criteria

CCG USE:	**Invoice ref:**	**Prior Authorisation requested by:**	
Is the procedure approved or declined? **Please indicate:**		**Name of Clinician**	
Name		**Contact number**	
Signature		**Date**	
Date			