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**Individual Funding Request (IFR)  
Referral Form**

This form must be typewritten

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Patient Details** | | | | | |
| NHS number | |  | | | | |
| Date of birth | |  | | | | |
| Patient's postcode | |  | | | | |
| Gender | | Man  Woman  Non-Binary  Prefer Not to say  Gender described in another way (please specify below)   |  | | --- | |  | | | | | |
| GP name | |  | | | | |
| GP practice name and address | |  | | | | |
| It is the responsibility of the requesting clinician to ensure that all the appropriate and required clinical information is provided. Requests will only be considered on the information provided within the request and supporting papers.  **DO NOT** include patient or trust / requesting clinician identifiable data beyond this point. Where there are large amounts of identifiable data included the request will be returned to you for redaction and resubmission.  **ALL SECTIONS MUST BE COMPLETED IN FULL**  **Treatment / Intervention / Procedure** | | | | | |
| Details of the treatment / intervention / procedure being requested | | |  | |
| Has the request been considered against the ICB commissioning criteria? | | | | Yes / No  If No, please refer to the clinical commissioning policies available at; [Commissioning policies :: West Yorkshire Health & Care Partnership (icb.nhs.uk)](https://www.westyorkshire.icb.nhs.uk/documents/commissioning-policies) | | | |
| Clinical detail to include;   * Background to the patient's clinical situation (relevant to this request) * Relevant medical history * Current symptoms * Functional issues | | | |  | | | |
| Previous interventions / treatments tried to date | | | |  | | | |
| Intended clinical outcomes | | | |  | | | |
| Are all relevant clinic letters attached? | | | | Yes / No | | | |
| Is this request urgent? | | | | Yes / No (If yes, please provide clinical reasons for urgency) | | | |
| Cost (if applicable) | | | |  | | | |
| Provider – proposed provider of the treatment / intervention / procedure | | | |  | | | |

**For Aesthetic procedure requests**

|  |  |
| --- | --- |
| Current weight |  |
| Current height |  |
| Current BMI (if relevant to the request) |  |
| BMI (please include all previous BMI measurements on record within the last 2 years (if relevant to the request) |  |
| Professionally measured breast size (if relevant to the request). | (Please submit professional bra fitting measurement with this form, including evidence of fitting) |
| Is photographic evidence attached in line with the criteria for the procedure? | Yes / No |

**Exceptionality**

|  |  |
| --- | --- |
| How is the patient significantly different? See definition set below;  **Definition of Exceptionality**   * The patient has demonstrated exceptional clinical circumstances in comparison to the cohort of other patients in the same clinical condition and (if relevant) at the same stage of progression, and because of that difference the patient is likely to receive material additional clinical benefit from the procedure / intervention that would not be plausible for any typical patient. * There are good grounds to believe that the requested procedure / intervention will be clinically effective for this individual patient. * It is considered that the requested procedure / intervention is likely to be a good use of NHS resources. |  |

**Referring Clinician Details**

|  |  |
| --- | --- |
| Name of referring Clinician |  |
| Designation of referring Clinician |  |
| Organisation name and address |  |
| Email address (if not GP Practice) |  |
| GP Practice email address |  |
| Telephone number |  |

**Patient Consent / GDPR**

|  |  |
| --- | --- |
| This IFR has been discussed in full with the patient or patient representative.  They are aware that they are consenting for the IFR team to receive and review confidential clinical information about their health to enable full consideration of this funding request. | Yes / No |
| In submitting this application, you are under obligation to advise the patient or patient representative of the details of the reasons for the decision. | I confirm that I will advise the patient or patient representative of the reasons for the decision  Yes / No |
| I understand that by indication, it is NOT clinically appropriate for the IFR team to contact the patient or patient representative with the outcome. I will be fully responsible to do this. | I will inform the patient or patient representative of the outcome and the reasons for the decision  Yes / No |

Date of completion of this form ……………………….

**Please submit this form via email to** [**ifr.wy@nhs.net**](mailto:ifr.wy@nhs.net)

**PLEASE CHECK THAT ALL SECTIONS HAVE BEEN COMPLETED IN FULL**

**INCOMPLETE FORMS WILL BE REJECTED**

**Equality Monitoring Form**

To make sure we provide the right services and treat everyone fairly, it is important for us to collect and analyse the following information.

Your information will be protected and stored securely in line with data protection rules and no personal information will be shared.

Please answer the questions below, some questions may feel personal, you do not have to answer them.

The answers to these questions will not affect the decision of the Individual Funding Request that is being submitted by your clinician.

1. **Who is this form about?** **(Please tick one option)**

Me

Someone else - using their information

1. **What is the first part of your postcode?**

**Example HD6, WF13**:

Prefer not to say

1. **What is your gender? (Please tick one option)**

Man

Woman

Non-Binary

Prefer Not to say

I describe my gender in another way.

**(Please tell us):**

1. **How old are you?**

**Example 42:**

Prefer not to say

1. **What country were you born in?**

(Please tick one option)

United Kingdom

Prefer not to say

Other country: **(Please tell us):**

1. **What is your religion?**

(Please tick one option)

No religion

Christian (including Church of England, Catholic, Protestant and all other denominations)

Muslim

Buddhist

Hindu

Jewish

Sikh

Prefer not to say

Other religion **(please tell us):**

1. **What is your ethnic group?**

(Please tick one option)

Prefer not to say

**Asian or Asian British**

Pakistani

Bangladeshi

Indian

Chinese

Any other Asian background **(Please tell us):**

**Black, Black British, Caribbean, or African:**

Caribbean

African

Any other Black background: **(****Please tell us):**

**Mixed or multiple ethnic groups**

White and Black Caribbean

White and Black African

White and Asian

Other Mixed background **(please tell us):**

**White**

English, Welsh, Scottish, Northern Irish or British

Irish

Gypsy or Irish Traveller

Roma

Other White background **(please tell us):**

**Other ethnic groups**

Arab

Any other ethnic background **(please tell us)**

1. **Are you disabled?**

Yes

No

Prefer not to say

1. **Do you have any long-term conditions, impairments or illness?**

(Please tick all that apply or go to next question if not relevant)

Prefer not to say

**Physical or mobility impairment:** (such as using a wheelchair, difficulty walking or using your hands)

**Hearing impairment:** (such as being D/deaf or hard of hearing)

**Sight impairment:** (such as being blind or partially sighted)

**Mental health condition:** (such as having depression, schizophrenia, bipolar disorder)

**Learning, understanding, concentrating or memory:** (such as Down’s Syndrome, stroke or head injury)

**Neurodivergent conditions:** (such as autism, ADHD and / or dyslexia)

**Long term conditions:** (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy**)**

Other:(please write in):

1. **Are you a carer? (Do you provide unpaid care or support to someone who is older, disabled or has a long-term condition)**

Yes

No

Prefer not to say

1. **What is your sexual orientation?**

Heterosexual / Straight

Gay

Lesbian

Bisexual

Other including Asexual, Pansexual

Prefer not to say

I prefer to use another term **(please tell us):**

1. **Are you Trans?**

(Trans is a term used to describe people whose gender identity is not the same as the sex registered at birth.)

Yes

No

Prefer not to say

1. **The cost of living can impact experiences of health and outcomes can you tell us about your current financial situation?**

(Please tick one option)

**Very comfortable** (I have more than enough money for food and bills and a **lot** left over)

**Quite comfortable** (I have enough money for food and bills, and **some** left over)

**Just getting by** (I have just enough money for food and bills and a **nothing** left over)

**Really struggling** (I don’t have enough money for food and bills and sometimes **run out** of money)

**I don’t know**

**Prefer not to say**

(We ask this question to help us understand the impact of income on experiences of services or health)

1. **Are you pregnant or have you given birth in the last 6 months?**

Yes

No

Prefer not to say

1. **Are you a parent / primary carer of a child or children, if yes, how old are they?**

(Please tick any that apply)

No

0 to 4

5 to 9

10 to14

15 to19

Prefer not to say

**Thank you for taking the time to complete this form.**