**MALE BREAST REDUCTION FOR GYNAECOMASTIA**

 **- PRIOR APPROVAL FORM**

**Please ensure all sections are completed and any requested supporting information is provided to ensure a prompt decision. Unless the patient fully meets the criteria, funding will not be approved unless there are exceptional reasons.**

**PART A – MUST BE COMPLETED FOR ALL REQUESTS**

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| **GP/CONSULTANT DETAILS** |
| Name: |  | GP Practice Code: |  |
| Address: |  | Trust: |  |
| Preferred Contact (Email) - Only NHS.NET addresses are acceptable: |  @nhs.net |
| **PATIENT’S DETAILS** |
| NHS No: |  | MRN (if applicable): |  |
| Date of Birth: |  |

**Requesting clinician – please confirm the following**

|  |  |  |
| --- | --- | --- |
| Patient Consent: The Patient hereby gives consent for disclosure of information relevant to their case from professionals involved and to the ICB. | Yes  | No  |
| I have informed the patient that this intervention will only be funded where the criteria are met. | Yes  | No  |
| I confirm that I have reviewed the patient against the commissioning criteria and that the information provided within this application is accurate. | Yes  | No  |

**PART B – MUST BE COMPLETED FOR ALL REQUESTS**

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| **ACCESS CRITERIA** |
| The reduction in breast tissue will be significant (i.e. 250g or more), with Simon Grade 3 or more | Yes  | No  |
| **OR**There is gross asymmetry **PLEASE PROVIDE ADDITIONAL INFORMATION (See Note)** | Yes  | No  |
| **AND** BMI of ≤ 25 | Yes  | No  |
| **AND** Screened for endocrinological/drug causes | Yes  | No  |
| **AND** post-pubertal | Yes  | No  |
| **AND** ≥ 18 years of age and the condition persistent for 2 years | Yes  | No  |

***Note:***

* + ***This must demonstrate that this is gross asymmetry and not just minor asymmetry***
	+ ***Photographic evidence is preferable***

**Please provide evidence below to support the information provided. Without evidence your application may be rejected. If you prefer you can attach supporting information, such as a clinic letter, rather than completing the box below.**

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| Supporting information: |

How to complete:

* Add GP/Consultant details
* Add Patient details
* Tick to answer yes or no to criteria listed under the procedure being requested
* Provide supporting information to evidence assessment in the free text area or attach supporting information such as clinic letter
* Email form to glicb.ifr@nhs.net
* Response will be sent from Gloucestershire ICB to preferred contact for reply within a maximum of 10 working days.