**FEMALE STERILISATION - 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.**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 gives consent for disclosure of information relevant to their case from professionals involved to the ICB. | Yes |
| I have explained that this intervention will only be funded where all criteria are met. | Yes |
| I have reviewed the patient against the commissioning criteria. The information provided here is accurate. | Yes |

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

**All criteria must be met before approval to proceed will be granted**

|  |  |
| --- | --- |
| The patient has received counselling about all other forms of contraceptives. Long acting reversible contraception has been discussed, tried, refused, or deemed unsuitable. | Yes |
| She is certain that her family is complete. | Yes |
| Vasectomy of the male partner is the preferred option and has been discussed, but is unwanted or impractical.  **Or**  The female does not have a permanent partner. | Yes |
| She understands that the sterilisation procedure is irreversible, and the reversal of sterilisation operation would not be routinely funded by the ICB. | Yes |
| She understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections. | Yes |

**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.**

|  |
| --- |
| Supporting information: |

How to complete:

* Add GP/Consultant details
* Add patient details
* Tick to answer yes to **all** 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](mailto:glicb.ifr@nhs.net)
* Response will be sent from Gloucestershire ICB to preferred contact for reply within a maximum of 10 working days