# VENTRAL MESH RECTOPEXY AND Stapled Transanal Rectal Resection (STaRR)

**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 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**

|  |  |  |
| --- | --- | --- |
| **ACCESS CRITERIA** | | |
| The risks, benefits and side effects of the procedure have been discussed with the patient and the patient wishes to be considered for this treatment. | Yes | No |
| **AND**  The patient has been considered by a Multidisciplinary Pelvic Floor Team, consisting of a Gynaecological Surgeon, two Colorectal Surgeons and a Pelvic Floor Physiotherapist this will not be quorate unless a representative from each of these groups is present. | Yes | No |
| **AND**  The Multidisciplinary Team (MDT) confirms that:  a) they recommend this treatment for this patient over all alternatives  b) the potential benefit outweighs potential harms  c) they are satisfied that the necessary capacity and expertise available to handle this intervention is in place in the proposed delivery setting. | Yes | No |
| **AND**  Conservative Management has been tried and has failed. This includes a selection of the following as appropriate for the individual: dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback and rectal irrigation. The patient will have undergone a proctogram and anorectal physiology tests. | Yes | No |
| **AND**  The patient has unresolved faecal incontinence or obstructed defecation syndrome. | Yes | No |

**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 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](mailto:glicb.ifr@nhs.net)
* Response will be sent from Gloucestershire ICB to preferred contact for reply within a maximum of 10 working days.